Student Name:	Grade:
Referring Teacher:	Date

Vision screening passed?	Yes	No
Hearing screening passed?	Yes	No
Motor screening?	Yes	No
Behavioral concerns?	Yes	No
Attendance concerns?	Yes	No
Does the intervention match the area of concern?	Yes	No

Was a screening conducted? If so, please attach results.	Yes	No

Academic Concerns		
Does the student's performance fall in the bottom 10% based on universal screening for the area of concern	Yes	No
How long in RTI?		
Is the student receiving daily instruction in the area of concern?	Yes	No
Tier 1		
Tier 2		
Tier 3		

Behavioral Concerns		
Office referrals	Number/Type:	
On chart for behaviors of concern?	Yes	No
Receiving daily/weekly counseling?	Yes	Yes
Receiving daily instruction in area of concern?	No	No
Tier 1		
Tier 2		
Tier 3		

Referral Committee Decision Date:	Accepted ______ Suspected Disability ______________________	Rejected ______	More Data Needed

Please attach all RtI data to referral form