



Teacher Referral for Gifted Testing

Please complete this form and return to the Director of A.L.E.

A. Name of Teacher Making Referral _____ Date _____

B. Student Information:

Student Name: _____ Grade: _____

Age _____ Language spoken at home _____

Does the child have an I.E.P.? (Please circle one) **Yes** or **No**

C. Please place a ✓ in the box next to the characteristics of giftedness this student exhibits.

Characteristic	Present
Comprehends Quickly	<input type="checkbox"/>
Retains Information / Excellent Memory	<input type="checkbox"/>
Demonstrates Curiosity / Makes Connections With Lessons	<input type="checkbox"/>
Advanced Vocabulary / Early Language Ability	<input type="checkbox"/>
Enjoys Math and Grasps Mathematical Concepts Before Others	<input type="checkbox"/>
Demonstrates Task Commitment, Persistence, or Grit	<input type="checkbox"/>
Is a Visual Thinker / Loves Puzzles, Maps, Brainteasers	<input type="checkbox"/>
Reasons Independently / A Problem Solver / Naturally a Leader	<input type="checkbox"/>
Exhibits Creativity / Original Thinker	<input type="checkbox"/>
Shows Intensity / Discomfort with Ambiguity / Sensitive	<input type="checkbox"/>
Eager for New Challenges	<input type="checkbox"/>
Demonstrates Perfectionism / Appears to be Underachieving	<input type="checkbox"/>