

## Freeport Area Care Team (FACT) Referral Form

Student First Name: \_\_\_\_\_ Student Last Name: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Referral Date: \_\_\_\_\_

### Please check behavior(s) you have witnessed.

- Decreased or low class participation
- Easily distracted or trouble concentrating
- Decrease in quality of work
- Poor short-term or long-term memory
- Low frustration tolerance
- Change in attendance/tardiness
- Frequent requests to leave the room
- Frequent requests to visit nurse
- Changes in extracurricular activities
- Increased irritability
- Argues with other students
- Cheating
- Change in friends
- Does not follow teacher instructions
- Drastic changes in appearance
- Observed talking about drinking alcohol or using controlled substances
- Other

### Please check strength(s) or resiliency factors.

- Is creative
- Considerate of others
- Strives to achieve his/her best
- Able to work independently
- Exhibits leadership
- Can accept redirection
- Appears to be connected to school
- Demonstrates good social skills

### Additional observable behaviors