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

*Contact the Director of Advanced Learning Experiences with any questions you may have.*
*602-861-2200 or schambers@wsd7.org*