

ACHIEVE CTARS REFERRAL

(Please complete all Information)

Student Name _____

Referring Teacher _____

Date of referral _____

Date Received _____

Reason for Referral: (Check all that apply)

Behavior Academic Attendance/Tardiness Health

Sp/Language other _____

Briefly describe Referring Problem:

Current Services: (Check all that apply)

Special Education ELL Title 1 small group Tier II reading

Outside Agency services (describe) _____

Other _____

Current Levels: (Indicate whether with ease or difficulty)

Reading _____ Math _____ Spelling _____

Writing _____ Social/Emotional _____ Fine/Gross Motor _____

Classroom interventions Attempted and Outcome: _____

Parent Contact Date and Outcome: _____

(Parent contact must be made before CTARS meeting is scheduled)

Achieve staff and/or Community Resource to Attend? _____

Is this an Emergency Referral? (If yes, Please explain) _____

Please return completed form to Social Work Office

