Newfoundland Labrador

Assessment Referral to Student Support Services Team

Referral Tracking Number

B	R	D.	S	C	H.	Y	R.	S	T	I	D
						1	1				

Entered by Student Support Services Team at the SST Meeting

Name: ______________________ Gender: ______________________

D.O.B.: (yyyy/mm/dd) ______________________ Mailing Address: ______________________

MCP: ______________________ ______________________

Parent/Guardian: ______________________ Telephone: ______________________

School: ______________________ School Telephone: ______________________

Teacher: ______________________ Grade: ______________________

Principal: ______________________ Guidance Counsellor: ______________________

Status

Is this a ***Reassessment***? No ☐ Yes ☐

If yes, please provide previous RTS#

B	R	D.	S	C	H.	Y	R.	S	T	I	D

Reason for Reassessment: ______________________

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Indicate Current Pathway (s): P1 ☐ P2 ☐ P3 ☐ P4 ☐ P5 ☐

Other Personnel Involved: ______________________

Does the student have an IEP? Yes ☐ No ☐ ***An ISSP?*** Yes ☐ No ☐

Hearing/Vision Check

Attach Most Recent Results: Hearing ☐ Vision ☐

(Teacher obtains from parent/guardian)

Referral Reason

What is the main area of concern?

- ☐ Academic – Specify ______________________
- ☐ Behaviour – Specify ______________________
- ☐ Social/Emotional – Specify ______________________
- ☐ Speech Language – Specify ______________________
- ☐ Others – Specify ______________________

What questions would you like answered as a result of this referral?

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Teacher Signature: ______________________ Referral date: ______________________

Authorized by the Department of Education
September 2010