

# School Based Team Referral Form



School Name:

|                                                                                                   |         |                                |                                |                               |                                                                  |
|---------------------------------------------------------------------------------------------------|---------|--------------------------------|--------------------------------|-------------------------------|------------------------------------------------------------------|
| Student Name:                                                                                     |         | Grade:                         |                                | Designation:                  |                                                                  |
| Name of Parent/Guardian:                                                                          |         |                                |                                | Date:                         |                                                                  |
| Date Contacted:                                                                                   | Method: | <input type="checkbox"/> phone | <input type="checkbox"/> email | <input type="checkbox"/> text | <input type="checkbox"/> in-person <input type="checkbox"/> note |
| Referred by:                                                                                      |         |                                |                                |                               |                                                                  |
| Classroom Teacher(s) (if different from above):                                                   |         |                                |                                |                               |                                                                  |
| Is the student of Indigenous Ancestry: <input type="checkbox"/> Yes / <input type="checkbox"/> No |         |                                |                                |                               |                                                                  |

| Area(s) of Concern                     |                                      |                                           |                                   |                                 |
|----------------------------------------|--------------------------------------|-------------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Instructional | <input type="checkbox"/> Behavioural | <input type="checkbox"/> Social-Emotional | <input type="checkbox"/> Physical | <input type="checkbox"/> Other: |

## Prior to making a referral to School Based Team, please ensure the following have been completed:

|                                                                                                                           |                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> I have explored Universal Strategies for this student. ( <a href="#">Please click for Link</a> ) |                                                                                                      |
| <input type="checkbox"/> I have reviewed the student's red file                                                           | <input type="checkbox"/> I have spoken to the current team involved with this student.               |
| <input type="checkbox"/> I have met/spoke with the student regarding the concern                                          | <input type="checkbox"/> I met with the school counsellor about this student's needs (if applicable) |
| <input type="checkbox"/> I have reviewed the most recent IEP/Learning Plan (if applicable)                                | <input type="checkbox"/> I have met with the case manager supporting this student (if applicable)    |
| What are the student's strengths, talents, likes or interests?                                                            |                                                                                                      |
| <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>                                                 | <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>                            |

## Describe one or two specific concerns prompting this referral.

|                                                                 |
|-----------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>•</li> <li>•</li> </ul>  |
| In what settings/situations does this occur <b>most</b> often?  |
| In what settings/situations does this occur <b>least</b> often? |

## School Based Team Referral Form

### Universal Strategies Explored ([Please click for Link](#))

Strategy you have tried to resolve this challenge? (pick one)

Strategy has been in place for: ☐ less than one month ☐ greater than one month

Results of implementing the strategy:

Strategy you have tried to resolve this challenge? (pick one)

Strategy has been in place for: ☐ less than one month ☐ greater than one month

Results of implementing the strategy:

**What type of assistance are you seeking? What specific question would you like to explore with the SBT?**

**Please provide any additional relevant information:**

**When the referral is completed, please hand in or scan and email to the chairperson of your SBT.**