

RIVER VALLEY BUILDING INTERVENTION TEAM Referral

Date rec'd by BIT _____

Referring Teacher(s) _____ Site _____ Referral date _____

Student _____ DOB _____ Age _____ Grade _____ New to district? _____

Date cumulative file reviewed _____ Student ever retained yes no -- if yes, when _____ ever in Special Ed? yes no

Recent year test data: WKCE reading level _____ STAR: date / GE _____

WKCE math level _____ Other test results: (Plan, Explore, ACT, etc.) _____

Comments & dates: (observations, consults w/ previous teacher(s) and / or SPED staff):

IMPORTANT: PLEASE attach copies of current grade and attendance report

Referring issue(s): academic social emotional/behavior absenteeism medical other _____

Briefly explain concern(s):

Known medical / emotional condition(s):

OTHER INFORMATION

Are prescribed vision aides worn? yes no If 'no' – why not?

Are prescribed hearing aides worn? yes no If 'no' – why not?

I've talked with site nurse re medication (type) _____
List any known side effects / impact on student:

Student has history of ear infections (may have to ask parent) yes no **if so, when?**

Student is habitually absent / truant yes no explain:

Student participates in off-site counseling with _____ how often?

Student participates in school counseling / group? yes no

Other: (ie: seizure disorder; sleep deprivation, family struggles, AODA concerns, diet, use of high-energy drinks, etc.)

Over – Triage Determination -- to be completed by site administrator and/or representative at Site BIT meeting

BIT TRIAGE DETERMINATION(s) - to be completed by BIT Administrator / representative

<input type="checkbox"/> Parent will be contacted on: _____ by: _____ <input type="checkbox"/> Parent & site BIT meeting to be held on _____ Attendees: _____	<input type="checkbox"/> Site SPED teacher consult [name _____] REASON: <input type="checkbox"/> Consult with District ESL coordinator
<input type="checkbox"/> Site Counselor / groups	<input type="checkbox"/> S&L and/or OT - consult -- referral (circle)
<input type="checkbox"/> School Psychologist will:	<input type="checkbox"/> School Site Nurse will:
<input type="checkbox"/> School Social Worker will:	<input type="checkbox"/> Behavior plan will be completed by: _____ On or before _____
<input type="checkbox"/> Title or after-school assistance – be specific	<input type="checkbox"/> "At-Risk" Program / GED Track – be specific with names / dates
Other:	Other

Reason(s) to Proceed Directly to: Tier 1 Interventions Tier 2 Intervention 504 evaluation SPED referral _____

Staff Responsible for: Tier 1 Interventions Tier 2 Intervention 504 evaluation SPED referral _____

Copies to : _____