Referral To ❑ Student Assistance Program (SAP) ❑ Student Success Team (SST)	**Request for Assistance (1.0)** **San Francisco Unified School District** School Site: _____	*Attach photo of student if available*

--CONFIDENTIAL: please do not leave out for others to read--

Student: (Last, First)	Grade	Gender M F	DOB	Ethnicity	HO#
Parent/Caregiver	Home Language		Telephone Number		
Name of Person Making Request	Your Title		Classroom or Telephone Extension		

1. Student's Strengths

- ☐ Able to problem solve
- ☐ Articulates feelings/needs
- ☐ Asks for help
- ☐ Attentive in class
- ☐ Cooperates with others
- ☐ Demonstrates sense of humor
- ☐ Enjoys math
- ☐ Enjoys reading
- ☐ Follows instructions
- ☐ Helpful to others
- ☐ Listens well
- ☐ Makes/maintains friendships
- ☐ Negotiates/compromises
- ☐ Participates in class
- ☐ Regular Attendance
- ☐ Other: _____

2. Your Concerns about Student

Please check and provide additional details:

❑ Academic

❑ Attendance

❑ Emotional or Behavioral

❑ Family/home

❑ Physical Health/Medical

❑ Other

3. Prior Interventions

- ☐ Behavioral interventions
- ☐ Classroom modifications
- ☐ Instructional modifications
- ☐ Consult w/ CLAD, BCLAD, or ELD certificated staff *(for EL students)*
- ☐ Met with student
- ☐ Offered tutoring/after-school program
- ☐ Spoken to/met with parent/caregiver
- ☐ Other:_____

Please describe your interventions and strategies, including length of time tried and response by student.

========== *Complete if student is referred to SST*==========

4. Student Profile Section (SAP/Counselor/SST Team to complete):

STAR 9 (Two previous yrs): Year	Reading	Lang	Math

CELDT Scores:
Students' primary language proficiency assessment results:

Support Services student is currently receiving:

❒After-School Prog ❒GATE ❒ ELD/ELL
❒Tutoring ❒Mentoring ❒ Peer Resources
❒ IEP ❒504 Plan ❒Foster Youth Services (FYS)
❒Mental Health ❒Physical Health ❒ Other:

Health Most recent Physical Exam: _____
Immunizations: Complete Incomplete: _____
Chronic health conditions?

Screening	***Date***	***Status –Pass/Fail***	***FU required?***
Vision			
Hearing			

5. Date family notified re: referral to SST:_____ Results:_____

==========*Feedback to Referring Person*==========

Date Referral Processed	Primary Contact Person

Action Items Planned	Who Will Follow-up
1.	
2.	
3.	

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