Central Bucks School District

Student Assistance Program

CONFIDENTIAL REFERRAL FORM

To: Student Assistance Team Members

From (Optional): _____(Name and/or title)

Date: _____

Student: _____
Please return this form in an envelope marked CONFIDENTIAL to the Guidance office.

Reason for concern; include any additional details you think necessary to include:

Observations and reasons for referral (check all that apply):		
ACADEMIC ____grades declining ____poor attendance ____grades inconsistent w/ standard. tests ____tardy for class ____does not follow oral directions ____unprepared for class ____does not follow written directions ____slow rate of work ____incomplete assignments ____poor study habits ____poor attitude ____poor motor skills ____inconsistent assignment completion ____disorganized ____appears apathetic ____doesn't ask for help Other: _____ _____	**BEHAVIORAL & SOCIAL** ____disruptive ____physically abusive ____leader ____follower ____defiant ____verbally abusive ____shy/withdrawn ____disrespects authority ____overly active ____emotional outbursts ____lacks selfcontrol ____disrespects property ____often off-task ____cheats ____poor peer relationships ____attention-getting behavior ____selfabusive behavior ____unable to concentrate ____ inappropriate behaviors ____lacks self-confidence ____disturbs other students Other: _____ _____	**PERSONAL** ____poor hygiene ____inappropriate dress ____sleepy/lethargic ____frequent trips to nurse/ bathroom ____unexplained injuries Other: _____ _____