

**SCHOOL BASED INTERVENTION TEAM
INITIAL REQUEST FOR ASSISTANCE**

Student's Name: _____ DOB: _____

Grade: _____ Age: _____ School: _____

Parent: _____ Phone: _____

Address: _____

Referring Source's Name: _____

Relationship to Student:

- | | | |
|--|--|---|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Regular Education Teacher | <input type="checkbox"/> School Based Intervention Team |
| <input type="checkbox"/> School Administrator | <input type="checkbox"/> Outside Agency Representative | <input type="checkbox"/> Part C Representative (Pre-School) |
| <input type="checkbox"/> State Agency Representative | <input type="checkbox"/> Student Himself / Herself | <input type="checkbox"/> Other |



Date Initial Referral Received by Principal/Designee:* _____
(SCHEDULE SBIT TO MEET WITHIN 10 BUSINESS Days!)

This referral is for the School Based Intervention Team to: (Check one or more that apply)

- Request for a Personalized Learning Plan
- To review the merit and justification of a referral for a section 504 evaluation.
(The parent and 504 Coordinator MUST be invited.)
- To review the merit and justification a referral for a special education evaluation.
(The parent and Special Education Teacher MUST be invited.)

Directions: Check the general area(s) of concern you have about the student that is interfering with the student's academic success.

- | | | |
|--|--|---|
| <input type="checkbox"/> Academic Performance - Behavior | <input type="checkbox"/> Interpersonal Relationships | <input type="checkbox"/> Personal Hygiene |
| <input type="checkbox"/> Academic Performance - Learning | <input type="checkbox"/> Listening - Behavior | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Listening - Learning | <input type="checkbox"/> Rules and Expectations |
| <input type="checkbox"/> Emotional or Physical Well- Being | <input type="checkbox"/> Math | <input type="checkbox"/> Social Interactions |
| <input type="checkbox"/> Group Behavior | <input type="checkbox"/> Medical | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Hyperactive-Impulsive | <input type="checkbox"/> Motivation | <input type="checkbox"/> Spelling |
| <input type="checkbox"/> Inappropriate Behavior | <input type="checkbox"/> Organization | <input type="checkbox"/> Writing |

Signature of referring source or of person completing this form if this request is made orally or by phone:

_____/_____/_____
Submit this request to the principal / designee. This Request may be done in writing or orally.

If an oral request is given, this form should be completed by the Building Administrator / Designee.

* This Date is to be used to begin the 65-day timeline if a referral for a section 504 or special education evaluation.