Resource Teacher of Literacy

Masterton/Central Wairarapa
C/ – Douglas Park School P O Box 313, Masterton
Phone (06) 370-0189

REFERRAL FORM

For confidentiality please do not fax this form: Post or hand deliver

Referral Date ____ /____ /____

What is the main focus of this referral				
Individual Student Yes / No (Please tick appropriate box)			Teacher Support	General Assessment /Advice
Reading Processing ☐	Reading Comprehension ☐	Writing ☐	Oral language ☐	

School		
	School: Email:	M.O.E Number
	Class Teacher: Email:	Phone:
	Withdrawal space available in the school: Yes / No	Fax:

Student			
	First Name:	Surname:	D.O.B ____ /____ /____
	Age at Referral:	Year Level:	Male / Female
	NSN: National Student No	Ethnicity:	
	Home Address:	Attendance: Very good / Sat / Poor	
		Health:	Behaviour:

Family			
	Parents or Caregivers Names		Day Phone:
			Home Phone:
	Parents/Caregivers have been notified of this referral Yes / No		Language Spoken at Home:

Reading Recovery			
	Yes / No	Year Attended:	Referred on: Yes / No
	Book Level at discontinuance:		Burt Word at discontinuance:

Current Instructional Level		
	Date Taken: ____ /____ /____	(enclose a copy of running record)
	Reading Level and Age:	Identify Test Used:
	% Acc: % Comp:	S.C Rate: Seen / Unseen
	Independent Reading Level:	Burt Word Level:

Star Stanine

(Complete if Appropriate) Date of Assessment: ____ /____ /____

		Stanine:
Word Recognition		
Sentence Comprehension		
Word Recognition		
Sentence Comprehension		

P A T

(Complete if Appropriate) Date of Assessment: ____ /____ /____

Listening Comprehension	Reading Comprehension	Reading Vocabulary

W ritten Language

(Complete if Appropriate) Date of Assessment: ____ /____ /____

Clay Observation Survey		National Writing Exemplars Curriculum Level	AsTTle Writing Curriculum Level	Spelling Test *(Please tick appropriate box)*		
Sounds	Vocabulary			Burt	Peters	Other
				Age		Score

Please Include a dated, independently written sample

Agencies

State Current Involvement or Past Involvement *(Dated)*

GSE	RTLB	Speech Language Therapist	CYPS	Other: (Please State)

Summary of support and extra literary assistance provided for this child by School / Class Teacher to date:

Please attach other relevant information

Signed

Name/s and Position of Person/s Initiating this Referral

Principals Signature:	Class Teachers Signature:

It is recommended that a copy of this go in Child's file