Fort Lee Public Schools

Parent Referral to Child Study Team

Student Name:		Birthdate:	Age:
Parents' Names:			Grade:
Home Address:		School:	
Telephone (H):		Telephone (C):	

To the Parent:
The following referral form is a request for the Child Study Team (CST) to determine whether or not a comprehensive (re)evaluation of a student should be undertaken. The CST must determine, based on the information submitted with this referral, if the student appears eligible for special education and/or related services due to an educationally handicapping condition [N.J.A.C. 6:28-3.4(a)]. The parent(s) or legal guardian must be provided with 15 days notice prior to forwarding this referral to the CST [N.N.A.C. 6-28-3.3(b)]. Upon receipt of the referral, the CST will make its determination and inform the referring agent of its determination.

A. **Reason for Referral** (Please let specific concerns or questions you have about your child; why is it important that your child be evaluated now?)

B. **Previous Interventions** (Include copies of neurological, psychiatric, speech and language, psychological or learning readiness evaluations.)

C. **Support Services** (Indicate all private support services or therapies the child receives.)

D. **Behavioral Referrals** (If this is a behaviorally based referral, discuss all actions taken and the manner in which the student's behavior interferes with his/her or other's learning).

E. **Physical Examination** - Attach latest pediatrician report.

F. **Vision/Hearing** - Attach doctor's reports of these areas [N.J.A.C. 6:28-4.4(d)(e)].

G. **Personality Inventory for Children / Modality Inventory/ Self Help/ Social Profile Questionnaire** (complete and attach with this form).

Referred By: ______________________________ Date: ______________

Supervisor, Special Education Signature: ______________________ Date: ______________
(indicate review of form)

Modality Analysis of Current Problems

1. General Information:

Child's Name: ______________________ D.O.B: ________ Age: ______ Sex: _____

Child's Address: ____

2. Behavior: (Many of these questions can be posed to the child by the therapist.)

The 3 things my child likes to do most at home are:

1. ____
2. ____
3. ____

List the sports that your child likes most to take part in: ______________________
____

List your child's favorite hobbies (e.g. reading, stamps, piano, etc.) ______________
____

List chores that your child has (e.g. paper route, making bed, taking out garbage, etc.) __________
____

How much does your child like each of the following games or activities? (Rate each one from 1= not at all; to 5 = great deal.)

Playing cards _____	Reading a good book _____	Checkers _____	Coloring or drawing _____
Science _____	Math _____	Talking to a friend _____	Watching T.V. _____
Playing a team sport ____	Playing with a pet _____	Video Games _____	Fantasy Games: _____

Others: ____

Your child's favorite T.V. shows are: ______________________________

Your child's favorite games (e.g. Legos, Lotto, checkers, etc.): ______________________
____

3. Description of Presenting Problems:

What specific problems have led parents to seek assistance? ______________________________
____
____
____
____
____

Was therapy recommended by a teacher, physician, counselor, etc? ___________________________
____

Which of the problems described above is of greatest concern? ______________________________
____
____

On the scale below, estimate the severity of your child's problem(s):

From father's point of view:

Mildly upsetting ________	Moderately upsetting ____________	Very Severe ________	Extremely Severe ________

From mother's point of view:

Mildly upsetting ________	Moderately upsetting ____________	Very Severe ________	Extremely Severe ________

When did each of the problems described above first appear? _______________________________
____
____
____

In which situations or in whose presence does the child most often exhibit the problems? ___________
____
____
____

When, and in which situations, does your child display his/her best behavior? ____________________
____
____
____

Has your child been to a counselor or therapist before? Yes __________ No __________

If yes, give name of person, title, dates seen, type of treatment and results: ____________________
____

4. Developmental History:

Complications during pregnancy:

Infections? ____________________ Drugs Taken? ____________________ Other: __________________

Child's birthweight: _____________ Caesarian delivery? ________________ Breech delivery? __________

Was child breathing at birth? _____ Was child premature? _______________ Apgar score (if known): ____

Other problems at time of birth ____

Breast or bottle fed?_____________________ As an infant, did you child make eye contact easily? _____

Did he or she smile at others prior to about 6 months of age? ____________________________________

Did he or she sit up by him/herself prior to about 8 months? ___________________________________

As an infant, was he/she overly afraid of others? ____

At about what age did your child sleep through the night? ______________________________________

At about what age did your child begin to crawl or scoot? ______________________________________

At about what age did he/she begin to walk on his/her own? _____________________________________

At about what age did your child use his/her first words? _______________________________________

Did your child have any feeding problems? ________ ____

Were mother or father ever separated from child for an extended period during infancy or early childhood?
____

Has your child ever experienced a serious trauma or accident? (e.g. caught in a fire, attacked or assaulted, witnessed a death, etc.) If yes, please explain. ____
____

Who were the child's primary caregivers during infancy and early childhood? ___________________________
____

Is your child adopted? __________________________ If yes, at what age? _________________________

Do any members of your family suffer from alcoholism, epilepsy, depression, or other "mental disorder"?
____

Has your child ever been hospitalized? _________ At what age? ________ For how long? ___________

Has your child ever had a high fever that was hard to lower? ______ If yes, please explain: ______________
____

What is your child's height? ______ ft. ______ inches What is your child's weight? ________ lbs.

Has child ever attempted suicide? Yes _____ No ______ Has your child ever made suicidal comments? ____

Circle any of the following that apply to your child:

Acts too young for his/her age	Cruel to animals	Drinks alcoholic beverages
overeats	clumsy	Refuses to talk
Accident prone, gets hurt a lot	steals	Shows off and clowns
Acts impulsively	cheats	Sucks thumb
Takes drugs	Hits other children	Destroys property
smokes	Is aggressive	Wets bed
Plays with genitals in public	Tortures animals	Behaves like opposite sex
Runs away from home	Can't sit still, is restless	smears/plays with bowel movements
Swears, uses obscene language	Disobedient at home	Overconcerned with being neat
Is withdrawn, shy	Problems with sleep	lies
Nervous tics	Has temper tantrums	bullies
Difficulty controlling bowels	procrastinates	Acts older than his/her age
Sets fires		

What specific habits or behaviors would you like to see your child change? ______________________________

____

____

What specific behaviors would you like your child to show more of? ______________________________

____

____

5. Feelings:

Circle any of the following feelings that apply to your child:

sad	confident	moody	whining	happy
guilt	excitable	dreamy	relaxed	energetic
worries	depressed	bored	hostile	unhappy
jealous	tense	anxious	Cries a lot	doubtful
helpless	angry	fearful	lonely	

Does your child fear certain situations? Yes _____ No _____ Which situations? ____________________________

____

Does your child fear certain people? Yes ____ No _____ Who? ____________________________________

____

Please name other fears (e.g. animals) that your child has: ______________________________

____

When are these fear worse? ____

When are they not as bad? ____

When does your child feel happiest? ____

____

When does your child feel saddest? ____

____

What things make your child angry? ____

____

What hobbies, games, or sports make your child happiest? ____________________________

____

6. Physical Sensations:

Does your child have any of the following? (please circle)

Visual problem	constipation	Hearing things
Hearing problem	Has sexual feelings	palpitations
dizziness	Skin problem	Unable to relax
nausea	blackouts	Gets sick before school
headaches	Stomach aches	Doesn't like to be touched
fatigue		

7. Imagination:

Does your child have many dreams? Yes _____ No _____

Is he able to describe them to you? Yes _____ No _____

Please describe dreams that your child seems to have often: ________________________________
____
____

Does your child have nightmares? Yes ____ No ____

Please describe any nightmares: ____
____
____

Does your child see or hear people or things that aren't there? Yes _____ No _____

If your child sees or hears things, please describe: ______________________________
____
____

Are there certain times and places when your child reports seeing or hearing things? Yes ___ No ____

If yes, please describe: ____
____

Does your child daydream a lot? Yes _____ No ______

If yes, please describe: ____
____

Is your child afraid of the dark? Yes _____ No _____

Does your child play a lot of "make believe" games? Yes ______ No _____

If yes, please describe: ____
____

Who are your child's favorite heroes? (e.g. Superman, Mr. T., storybook or comic book characters) _________
____

Does your child have an "imaginary friend"? Yes _____ No _____

If yes, please describe: ____
____

8. Cognition:

Please put a checkmark or an (x) next to the kind of thoughts that are typical of your child:

I must do well and be approved of	_____	I shouldn't show my feelings	_____
I must get what I want	_____	Adults should be perfect	_____
I must be comfortable and life should be fun	_____	There's only one right answer	_____
It's awful if others don't like me	_____	I must win	_____
I'm bad if I make a mistake	_____	I shouldn't have to wait for anything	_____
Everything should go my way	_____	I am stupid	_____
I should always get what I want	_____	I'm not good at anything	_____
The world should be a fair place	_____	I am bad	_____
People are always out to get me	_____		

Circle each of the following statements that your child might think about him or herself.

I'm pretty good at school work.

I'm just as smart as other kids in my class.

If I get bad grades it's my own fault.

I find it pretty hard to make friends.

If someone likes me, it's probably because of the way I treated them.

I'm a pretty good person.

I wish more kids liked me.

I feel that I'm better than most kids my age at sports.

I'm pretty good at new subjects in school.

Does your child have thoughts that occur over and over? If so, please describe them. ____________________

____

Does your child think before doing something?

Never ____________________ Sometimes ____________________ Often ____________________

When faced with a problem, does your child think about different ways of solving it?

Never ____________________ Sometimes ____________________ Often ____________________

Does he or she tend to consider the consequences of his or her actions?

Never ____________________ Sometimes ____________________ Often ____________________

When faced with a problem, does your child usually think about a plan or strategy to solve it?

Never ____________________ Sometimes ____________________ Often ____________________

9. Interpersonal:

A. Family

Do you feel that your child is too dependent on you, your spouse or some other adult? (if yes, please explain)
____

Which brother or sister does your child play with most? ______________________________

In what areas of family life does there seem to be the most friction or problems? ______________
____

Who is the most successful in getting your child to do things?
Mother ____________________ Father ____________________ Other (name) ________________

Do you and your spouse agree about the best kind of discipline to use with your child? Yes ___ No ____

What type of discipline is most successful with your child? ____________________________
____

How frequently do you and your child argue? Never ___________ Sometimes _________ Often _________

When do you and your child seem to have the most fun? ______________________________
____

Have you gone, or are you currently going through a divorce or separation? Yes _______ No ________

If yes, please tell how old your child was at the time and any reactions he/she displayed. ____________
____

B. School

What does your child seem to like most about school? ______________________________
____

What grades does your child receive in school? ___________________________________

Does he/she get into trouble at school? If yes, please explain. _________________________
____

When your child's teacher informs your that he or she has misbehaved in school, how do you respond?
____

Does your child ever refuse to go to school? If yes, please explain. _______________________
____

Does your child get sick (e.g. headaches, stomach aches, nausea, etc.) on school days?
Never ________________ Sometimes ____________________ Often ________________

Does he or she do homework without being forced to? If not, please explain. ____________________________

____

How frequently is your child absent from school? Never _________ Sometimes ________ Often _____________

What are the reasons for his or her absences from school? ____

Is your child disobedient at school? Never _________ Sometimes ________ Often _____________

C. Friends

When not in school, how often does your child play with other children?
Never ___________________ Sometimes ______________________ Often ____________________

Does your child play mostly with children:
Older than him or her? _____ The same age as him or her? ____ Younger than him or her ? ____

What kinds of activities does your child do with his/her friends? (Please circle.)

Watch T.V. Play sports Play video games Play board games

Please list others: ____

Circle any of the following that apply to your child.

Argues a lot

Clings to adults

Is cruel or mean to other children

Fears or complains no one loves him/her

Likes to be alone

Not liked by peers

Is easily bullied

Hangs around with others who get in trouble

Defiant, talks back to adults

Is too dependent on adults

Easily jealous

Gets in a lot of fights

Gets teased a lot

Unable to share

Overconforms to other children

10. Biological Factors:

Do you have any current concerns about your child's physical health? Please specify. ______________________

____

Does your child eat three well-balanced meals each day? If not, please explain. __________________________

____

____

Please list any medicines that your child is currently taking, or has taken during the last 6 months (including both prescription and non-prescription):

____

____

Does your child get regular physical exercise? If not, please explain. ______________________

____

Circle any of the following that apply to your child or to members of your family.

Neurological disease	asthma	Thyroid disease
Cardiovascular disease	diabetes	Kidney disease
Infectious diseases	cancer	epilepsy

Other: ____

Has your child ever lost consciousness or had a head injury? If yes, please explain. ____________

____

Please describe any hospitalizations your child has had. ______________________________

____

____

Please describe any surgery your child has had. ___________________________________

____

Please describe any accidents or injuries your child has suffered (give dates). _______________

____

____

Please circle any of the following that apply to your child:

Feels dizzy	Alcohol or drugs	Wets bed	allergies
Eats junk food	Hearing disorder	overweight	diarrhea
nausea	constipation	headaches	Sleep problems
Eye problems	Heart problems	Feels sick a lot	Poor appetite
vomiting	Finicky eater	acne	Soils pants
Stomach aches or cramps			