## RESOURCE TEACHERS: LITERACY CHRISTCHURCH EAST CLUSTER

Updated 8.3.13

## **Student Referral Form**

When completed, please e-mail this form, with other relevant documentation, to: rtlitreferral@chcheast.school.nz

Date:				
School Name:	Phone:			
School MOE Number:				
SENCO	E-mail:			
Contact Teacher name:	E-mail:			
Student Name:	Student date of birth:			
Gender:	Ethnicity (from SMS/enrolment form):			
NSN:	Year Classification:			
Age at date of referral: years months	How long has this student been at your school?			
Attendance (please circle) Regular/Irregular Comment:				
Is any language other than English spoken in the student's home? If yes, please specify.  Is the student currently receiving additional English Language Learning Support? If yes, please specify.  Is the student a foreign fee payer?				
Parent's/Guardians Names:	Home address:			
Phone:				
Support Agencies Involved (Please specify which agencies have previously been and are currently involved with this child)				
Psychologist:				
Speech Language:				
RTLB:				
Vision/Hearing:				
Other:				

Reading Reco	overy ent received Reading Recove	ery?		
Last date in R	leading Recovery:			
Reading level	attained:			
Number of w	eeks in Reading Recovery:			
Number of R	eading Recovery sessions:			
Reading Reco	overy outcome:			
If student is b	peing referred on to RTLit fro	om Reading Recovery, pleas	se copy the final Observation	
Survey inforn	nation.			
	Score	Stanine		
Letter Id				
C.A.P.				
Word Test				
Writing				
H & RS				
Burt		Equivalent Age (EAB)	Equivalent Age Band (EAB)	
Writing Natio	onal Standard: onal Standard:			
	uctional Text Level:  n unseen running record.	OR Reading Year Lev	vel:	
Normed Ass	sessment:			
e-asTTle Rea	ading	aRs:	Level:	
e-asTTle Writing		AWs:	Level:	
STAR Readir	ng Score		Stanine:	
PAT Vocabu	lary Score		Stanine:	
PAT Compre	ehension Score		Stanine:	
	t currently being instructed specify the group size: eing made?	in a guided reading group?		
Please add ar	ny additional comments:			