TSNA Referral Form

Student: _____ **Date of Referral:** _____		
DOB: _____	**Age:** _____ **Grade:** _____	**Gender:** _____
Eligibility: _____	**Placement:** _____	
School: _____	**Case Carrier:** _____	

Additional Support Providers:

- ☐ **Clinical Counselor/ School Psychologist**
- ☐ **Speech Therapist**
- ☐ **Occupational Therapist**
- ☐ **Mental Health**
- ☐ **APE Specialist**
- ☐ **Other:**

Reason for Referral: _____

_____

Other Areas to Consider: Behaviors/Medical Impacting Learning

Health/Personal Care Issues/Medical

- ☐ Specialized health care plan
- ☐ G-Tube
- ☐ Medications:

Type: _____

Frequency/Duration:

_____

_____

- ☐ Suctioning
- ☐ Specialized Food preparation
- ☐ Personal Care:

_____

_____

- ☐ Diaper Changing
- ☐ Feeding-Full support
- ☐ Seizures weekly
- ☐ Lifting/Transfers
- ☐ Physical Support/ Positioning
- ☐ Limited mobility
- ☐ Allergies
- ☐ Chronic health Condition: _____

_____

- ☐ Other: _____

Behavior and Safety

- ☐ Behavior Goal
- ☐ Behavior Intervention Plan
- ☐ Aggressive
- ☐ Self Injurious
- ☐ Property Destruction
- ☐ Self Stimulatory behavior
- ☐ Escape/Avoid Task/Demand
- ☐ Anxiety
- ☐ Difficulty regulating emotions
- ☐ Schedule of reinforcement:

_____

_____

- ☐ Difficulty remaining in area:
  - ☐ Instruction
  - ☐ Play ground
  - ☐ Other: ___

_____

- ☐ Dangerous running safety:

_____

- ☐ Other: _____

_____

Instruction/ Educational Benefit

- ☐ Behavior interfering with learning
- ☐ Attending/ engaged in learning
- ☐ Staying on task
- ☐ Waiting
- ☐ Difficulty following directions
- ☐ Difficulty accepting prompts
- ☐ Prompt dependent
- ☐ Difficulty with organization
- ☐ Intensive instructional teaching (1:1 teaching)
- ☐ Requires small group instruction
- ☐ Prompting
- ☐ Visual: _____%
- ☐ Gesture Modeling: ____%
- ☐ Verbal: _____ %
- ☐ Physical: _____ %
- ☐ Assistive technology
- ☐ Signing: _____ %
- ☐ Other: _____

Inclusion/Mainstream

- ☐ Inappropriate social skills
- ☐ Social supports
- ☐ Direct support with peer interaction
- ☐ Support to transition
- ☐ Within classroom
- ☐ On campus
- ☐ Turn taking
- ☐ Waiting
- ☐ Other: _____

_____

_____

Rational for requesting TSNA

Review of Data Indicators:

☐ Yes ☐ No Has specialized health care plan requiring care by specially trained staff (G-Tube, Tracheotomy, Catheterization).
☐ Yes ☐ No Has specialized health care procedures, medications and/or equipment.
☐ Yes ☐ No Has limited mobility or physical limitations requiring assistance.
☐ Yes ☐ No Health related mobility or physical limitations requiring assistance.

Behavior Support:

☐ Yes ☐ No Data indicates lack of sufficient behavior progress, despite fidelity of behavior plan.
☐ Yes ☐ No Behavior plan was revised due to insufficient behavior progress. Student continues to show lack of: _____.
☐ Yes ☐ No Exhausted all existing and natural supports contained in the IEP.
☐ Yes ☐ No The request for TSNA is related to the additional support required to implement the interventions in: _____.
☐ Yes ☐ No All interventions are developmentally appropriate for the student.
☐ Yes ☐ No Behavior plan is written clearly enough for new staff to understand and implement.
☐ Yes ☐ No All implementers understand and/or have training in the strategies contained in the plan.

Instruction/Educational Benefit:

☐ Yes ☐ No Exhausted all academic/instruction interventions available within the classroom.
☐ Yes ☐ No The request for TSNA is related to the additional support required implement the academic/instructional interventions in the IEP due to behaviors interfering with learning.
☐ Yes ☐ No All academic/instructional interventions are developmentally appropriate for the student.
☐ Yes ☐ No IEP goals were revised and data indicates continued concern with educational progress (attach SEIS progress reports): No. of goals met ☐ / ☐ not met.
Making progress ☐ yes or ☐ no.
☐ Yes ☐ No Data indicated student requires specialized instruction including direct instruction, Prompting, and support with organization and/or initiating tasks.
☐ Yes ☐ No Data indicates that repetitive instruction and practice is necessary to learn and retain skills.

Inclusion/Mainstreaming:

☐ Yes ☐ No Student needs adult support to facilitate appropriate social skills, including peer interaction.
☐ Yes ☐ No Data indicates student has difficulty with social skills, including peer interaction, which requiring adult support.
☐ Yes ☐ No Student needs adult support to facilitate transitions in the educational setting.
☐ Yes ☐ No Adult support required to facilitate transitions in the educational setting.
☐ Yes ☐ No Student needs staff in close proximity to monitor safety.
☐ Yes ☐ No Data indicates need for close proximity of staff to monitor safety.
☐ Yes ☐ No Student requires intensive instructional teaching, prompting, support with organization and/or initiating tasks in a lesser restrictive setting.
☐ Yes ☐ No Data indicates student requires specialized instruction including direct instruction, Prompting, support with organization and/or initiating tasks in a lesser restrictive setting.

Attach the Following Suggested Documents:

- ☐ Most recent IEP with documentation of the referral request
- ☐ Student schedule
- ☐ Health records
- ☐ Specialized health care plan (If appropriate)
- ☐ Educational progress/assessments: Provide supporting evidence
  - ☐ Grades
  - ☐ Progress reports
  - ☐ Rate of homework completion
  - ☐ Documentation of duration for on-task behavior
  - ☐ Frequency and quality of social interaction
  - ☐ List of interventions/accommodations/modifications implemented
  - ☐ Discipline referrals
  - ☐ Work samples
- ☐ Current triennial assessment
- ☐ Student's behavior plan (BIP)
- ☐ Behavioral data summary of most current data on current level(s) of frequency, severity, and duration of behavior(s) (minimum of 30 days)

Other unique needs: _____
_____
_____
_____

This referral is made at the request of: _____

_____ _____
Person(s) completing Pre-Referral Form Date

_____ _____
Person(s) completing Pre-Referral Form Date

_____ _____
Person(s) completing Pre-Referral Form Date

_____ _____
Site Administrator or Designee Date

_____ _____
District Director's Signature Date

Review of Referral **(For Office Use Only)**
Reviewed by: _____ Date Reviewed: _____

☐ TSNA Assessment request IS recommended:
- ☐ Send home assessment plan and PWN
  Date Sent: _____ Received: _____ Timeline: _____
- ☐ Other Considerations: _____
  _____

☐ TSNA Assessment request IS NOT recommended:
- ☐ Hold IEP
- ☐ Review supports, accommodations, and/or modifications that are effective
- ☐ Add/Modify goals and objectives, supports, accommodations and/or modifications
- ☐ Revise behavior supports/plan
- ☐ Other recommendations to the IEP team: _____
  _____

☐ TSNA Assessment request IS UNABLE TO BE processed:
- ☐ Missing documents
  - ☐ Most recent IEP with documentation of the referral request
  - ☐ Student schedule
  - ☐ Health records
  - ☐ Specialized health care plan (if appropriate)
- ☐ Educational progress/assessment: Provide supporting evidence
  - ☐ Grades
  - ☐ Progress reports
  - ☐ Rate of homework completion
  - ☐ Documentation of duration for on-task behavior
  - ☐ Frequency and quality of social interaction
  - ☐ List of interventions/accommodations/modifications implemented
  - ☐ Discipline referrals
  - ☐ Work samples
- ☐ Current triennial assessment
- ☐ Student's behavior plan (BIP)
- ☐ Behavioral data summary of most current data on current level(s) of frequency, severity, and duration of behavior (s) (Minimum of 30 days)
- __ Missing IEP discussion regarding need for additional support

☐ Other: _____
_____
_____
_____