New Paltz Middle School
IST Referral Form

IST MISSION STATEMENT: The Instructional Support Team is a resource for teachers.
Its mission is to collectively suggest ways teachers can help students improve academically and/or
behaviorally through a multidisciplinary approach.

Student:_____Date:_____

Grade:_____   DOB:_____   Referred by:_____

Is this student an English Language Learner? ___yes___no

1. Areas of Concern: (Please mark any that apply)

Academic Issues:
Reading:
___Weak literal comprehension
___Weak Vocabulary
___Difficulty with phonics (omits, adds, substitutes, reverses letters, words or sounds when reading)
___Difficulty with fluency
___Reads below grade level

Writing:
___Difficulty with organizing written work
___Difficulty with mechanics of writing
___Difficulty with spelling
___Difficulty with written expression

Language:
___Difficulty expressing ideas verbally
___Needs questions or directions repeated
___Difficulty understanding abstract concepts

Math:
___Difficulty memorizing facts
___Weak calculation skills
___Difficulty applying math skills to word problems
___Difficulty following math procedures/ steps

Behavioral Issues:
___Distractibility
___Impulsivity
___Social skills
___Non-compliance
___Aggression
___Insubordination
___Withdraws from classroom activities

___Other:_____

Psychosocial or Mental Health Concerns:

___Suspected Drug/Alcohol Abuse   ___Depression

___Suicidal thoughts/ideations   ___Self-injurious behaviors

___Grief   ___Self Esteem

___Anxiety   ___Potential Dropout

___Peer difficulties   ___New student having trouble with adjustment

___Pregnancy   ___Avoidance

Organization:

___Does assignments/cannot find them

___Does not write down assignments

___Does not complete prep tasks

___Comes to class without materials

Health Concerns:_____

Attendance: _____Frequently Absent   _____ Frequently Tardy   _____ Leaves class/school Early

2**. Strengths:**

(Please check all that apply)

___Organized   ___Math

___Good Study skills   ___Good Writing Skills

___Friendly   ___Reading

___Cooperative   ___Good Verbal Skills

___Kind   ___Artistic

___Musical   ___Athletic

___Other:_____

3. Are there certain activities that the student prefers to do/tends to excel at?

_____

Procedural Check List:

When was contact made with the parent/guardian to discuss your concerns? ___/_____/____

What was the parent's feedback?_____

4. Did you inform the parent that you would be referring the student to IST?   _____Yes_____No

5. An administrator, classroom teacher and special education teacher will be present. Please indicate on the following list any other support staff you would like present.

_____ Remedial Reading

_____ Speech Therapist

_____ ESL Teacher

_____ Occupational Therapist
_____ School Social Worker
_____School Counselor
_____ School Psychologist
_____ School Nurse
_____ Additional Classroom Teacher
_____ Other _____

_____

Please indicate any of the above staff with whom you have consulted, if any: _____

_____

6. What measures have you taken to assist the student? (Please describe at least 3)

	Specific Strategies Implemented Tier I	Frequency and duration	Beginning Performance	Ending Performance
	Small group instruction Targeted intervention based on similar needs			
	1-1 Instruction 1-2 Targeted intervention based on similar needs			
	Preferential seating			
	Graphic Organizers			
	Peer Tutor/Youth Center Tutor			
	Positive Reinforcement			
	Behavioral Consultation/Strategies			
	Behavior Intervention Plan/Contract			
	Breaking down tasks			
	Copy of class notes			
	Classwork/Prep task modification			
	Test Modification			
	Repeating directions/paraphrasing			

Presenting information through different modes, verbally, visually)				
After School Help				
Use of technology Please Specify:				
GOAL assigned				
Parental Contact				
Other (describe):				

7. What additional school and/or community resources have been used to assist this student?

	Support Service	Frequency	Comments
	Reading Literacy		
	Writing Workshop		
	Math Literacy		
	Supportive Counseling		
	Social Group		
	OT/Sensory support		
	Reading Software		
	Mandatory GOAL		
	Summer School		
	Outside Tutoring		
	Speech and Language Services		
	Community Resources (list):		
	Other (describe):		

INSTRUCTIONAL STUDY TEAM PLAN

Date:
Is this a revisit?
Does this case need to be revisited?   YES_____   NO_____
If yes, the revisit date will be:
Members Present:
Background Information:

Student Needs/Goals:

STRATEGIES TO ACCOMPLISH THESE GOALS

* Person taking IST minutes, please initial here: _____

Intervention	Implementation Who? Where?	Frequency	Time Frame	Start Date	Progress Documentation

IST Liaison_____
Check-in date_____