

LCCTC CONFIDENTIAL
STUDENT ASSISTANCE PROGRAM
REFERRAL

Student Name:	Referral Date:
Address:	Phone:
School District:	Program:
DOB:	Sex & Gender Preference:

REASON(S) FOR REFERRAL TO SAP TEAM:
Please check all that apply.

ACADEMIC PERFORMANCE

- Decrease in class participation
- Drop in grades
- Does not follow directions
- Easily distracted or preoccupied
- Failure to complete assignments
- Cheating

CLASS ATTENDANCE DURING PAST MONTH

- Absenteeism
- Cutting Class
- Tardiness
- Frequent visitor to counselor/nurse (circle one)
- Pattern to absences noted: Day of Week _____ Test Days _____ (Y/N)

PHYSICAL OBSERVATIONS

- Deteriorating personal appearance
- Frequent cold-like symptoms (runny nose, watery eyes, cough)
- Glassy, bloodshot eyes
- Slurred or slowed speech
- Smelling of marijuana, alcohol, or tobacco
- Unexplained, frequent injuries

DISRUPTIVE BEHAVIORS

- Attention-seeking behavior
- Cheating
- Crying
- Defiance of rules
- Fighting
- Hyperactivity, nervousness
- Irresponsible, blaming, denying
- Lying
- Obscene language, gestures
- Sudden outbursts of anger
- Verbally abusive to others
- Other _____

ATYPICAL BEHAVIORS

- Change in friends
- Defensive (feels picked upon)
- Depressive behaviors
- Inappropriate responses
- Obvious mood swings
- Seeking adult advice without a specific problem
- Sexual behavior in public
- Talks freely about drug use
- Withdrawn, difficulty relating to others

LIST OBSERVABLE BEHAVIORS OR DIRECT COMMUNICATION FROM STUDENT

IF INSTRUCTOR REFERRED, HAS PARENT/GUARDIAN BEEN CONTACTED? YES___ NO___

IF “YES,” WHAT DATE, TIME AND HOW WERE THEY CONTACTED?

TEAM CASE MANAGER_____

DATE PARENT PERMISSION FORM WAS RECEIVED/SIGNED_____