

SAN FRANCISCO UNIFIED SCHOOL DISTRICT
Wellness/Student Assistance Program/Student Success Team
Request for Assistance (1.0)*
Wellness/SAP/SST

Referring Person	Class/Period	School	Grade	Date
Student	HO#	D. O.B.	Gender	Ethnicity
Parent/Caregiver	Phone Number	Student's Primary Language/Language of Home		Language Proficiency

1. Student's Strengths Noted	2. Reason for Request
<input type="checkbox"/> Regular attendance <input type="checkbox"/> Cooperative with others <input type="checkbox"/> Able to problem solve <input type="checkbox"/> Makes/maintains friendships <input type="checkbox"/> Negotiates/compromises <input type="checkbox"/> Articulates feelings <input type="checkbox"/> Good Listener <input type="checkbox"/> Other:	<input type="checkbox"/> Follows instructions <input type="checkbox"/> Participates in class <input type="checkbox"/> Sets goals <input type="checkbox"/> Helpful to others <input type="checkbox"/> Communicates needs <input type="checkbox"/> Asks for help <input type="checkbox"/> Sense of humor <input type="checkbox"/> Attentive in class <input type="checkbox"/> Academic <input type="checkbox"/> Attendance <input type="checkbox"/> Behavioral/Attitude <input type="checkbox"/> Health Issues <input type="checkbox"/> Family Concerns <input type="checkbox"/> Other:

3. Interventions/Modifications/Adaptations (Please describe in comments section below. Include length of time these have been tried):		
<input type="checkbox"/> Instructional modifications	<input type="checkbox"/> Caregiver conference	<input type="checkbox"/> Tutoring
<input type="checkbox"/> Classroom modifications	<input type="checkbox"/> Detention	<input type="checkbox"/> After-school program
<input type="checkbox"/> Other:		

COMMENTS: _____

***** (Referral Source - Complete To This Point) *****

4. Student Profile Section (Counselor/SAP/SST Team to complete):				
SAT 9 (Two previous years): Year	Reading	Lang	Math	District & Community-based services currently (c) or previously (p) received:
				GATE English Plus ELD/ELL Tutoring Special Education Grade(s) Repeated
				Mental Health Mentoring Peer Resource Other
Date of Vision Screening:		Results:		Date of Hearing Screening:
				Results:

5. Date of discussion with family regarding concerns, and explanation of the SAP/SST/Wellness process: _____
Results: _____

***** Feedback To Referring Person *****

<input type="checkbox"/> SAP/SST date:	<input type="checkbox"/> Referral to tutoring	<input type="checkbox"/> Met with caregiver, date:
<input type="checkbox"/> Referred to support services	<input type="checkbox"/> Met with student, date:	<input type="checkbox"/> Referred to After-school program
<input type="checkbox"/> Other:		

COMMENTS: _____

Wellness/SAP/SST/ Team Member

Date

Note: SAP/SST/Wellness team member: When making referrals, please copy and attach student locator card, current report card, and the 2.1 Teacher Input Form from each teacher. Careful consideration should be given to the impact of language, culture, health, and environmental factors in planning appropriate interventions, modifications, and adaptations.