

**CST/PST Tier 2 Initial Review Form**  
**(To be completed for students being referred for Tier 2 intervention)**

Child's Name: \_\_\_\_\_ Teacher: \_\_\_\_\_

Date of CST/PST meeting: \_\_\_\_\_

Members of the CST/PST: \_\_\_\_\_

\_\_\_\_\_

**Criteria for Tier 2 Eligibility**

After 6-8 weeks of Tier 1, the student demonstrates a lack of progress as indicated on the **Student Intervention Plan**  
and (please check all that apply)

- ☐ ELA score of 2 or below
- ☐ Standardized test scores at or below 40%ile
- ☐ F&P BAS remains below benchmark
- ☐ Continues to demonstrate poor classroom performance (observed over a period of time)
- ☐ Classroom assessments continue to indicate delay (observed over a period of time)
- ☐ Other: \_\_\_\_\_

**Recommendation:**

Continue Tier 1 Intervention \_\_\_\_\_ Anticipated date of follow up review (generally within 6 to 8 weeks): \_\_\_\_\_

Tier 2 Intervention \_\_\_\_\_ Frequency of Service \_\_\_\_\_ Duration of Sessions \_\_\_\_\_ Provider: \_\_\_\_\_

Anticipated date of Tier 2 review (generally within 6 to 8 weeks after initiation of services): \_\_\_\_\_

Rationale for CST/PST decision: \_\_\_\_\_

Targeted Area(s): \_\_\_\_\_

Date of parent notification: \_\_\_\_\_ Parent consent received? \_\_\_\_\_yes \_\_\_\_\_ no Date of receipt: \_\_\_\_\_