

# Special Education Referral Form

(To be completed at the Child Study meeting.)

Learner's Full Name: \_\_\_\_\_ Person Making Referral: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Sex: M F Month/Date/Year: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Grade: \_\_\_\_ Teacher: \_\_\_\_\_  
Address: \_\_\_\_\_ School District: \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (cell) \_\_\_\_\_

A. Describe your reasons for referring this student for special education assessment or reassessment.

B. You must submit two interventions (see pre-referral form) along with this referral, unless this is a reassessment or the interventions are waived by the special education team (pre-referrals are not required for early childhood or in emergency situations).

## C. Medical Information

1. Vision Screening Date: \_\_\_\_\_ Results: L \_\_\_\_\_ R \_\_\_\_\_
2. Hearing Screening: Date: \_\_\_\_\_ Results: \_\_\_\_\_
3. Receiving Medication: No \_\_\_\_ Yes \_\_\_\_

\*\* If yes, describe: \_\_\_\_\_

4. Family Physician: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

5. List Mental Health diagnosis or physical problems (attach copies of medical report if available).

D. Please check areas of concern. (The Assessment Determination Team reserves the right to determine what area(s) will be assessed.)

<input type="checkbox"/> Intellectual	<input type="checkbox"/> Sensory	<u>Transition</u>
<input type="checkbox"/> Academic	<input type="checkbox"/> Health/Physical	<input type="checkbox"/> Home Living
<input type="checkbox"/> Communication	<input type="checkbox"/> Social/Emotional	<input type="checkbox"/> Community Part.
<input type="checkbox"/> Motor	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Recreation/Leisure
<input type="checkbox"/> Adaptive Behavior	<input type="checkbox"/> Assistive Technology	<input type="checkbox"/> Jobs and Job Train.
<input type="checkbox"/> Information Processing	<input type="checkbox"/> Observations	<input type="checkbox"/> Post Secondary

## E. SAT or Child Study Team completes this section:

- Date Referral Reviewed by Child Study Team: \_\_\_\_\_
- Recommended Action:  Proceed with Special Education Due Process  
 Do Not proceed with Special Education Due Process
- Case Manager: \_\_\_\_\_
- Administrative Signature: \_\_\_\_\_
- Date Parent Permission Received: \_\_\_\_\_

Attachments: Prereferral form  
Medical Reports

