

**GRADE 7-12 REFERRAL FOR  
COMPREHENSIVE EDUCATIONAL EVALUATION**

<b>Student's Name</b>	<b>Birth Date</b> <b>Age</b>	<b>Gender</b> <b>Grade</b>
<b>Parent/Guardian Name</b>	<b>Address</b>	<b>Phone</b> <b>Home:</b> <b>Cell:</b> <b>Work:</b>
<b>Primary Language of Student's Home</b> ___ English  <b>Other:</b> _____	<b>School District</b>	<b>School</b>

**CURRENT EDUCATION PROGRAM**

\_\_\_ General Education    \_\_\_ Private/Home School    \_\_\_ School Counseling    \_\_\_ Alternative School

\_\_\_ Title 1 Classes: \_\_\_\_\_

\_\_\_ Limited English Proficiency    \_\_\_ Other: \_\_\_\_\_

**REASON FOR REFERRAL**

**Why is the student being referred for a comprehensive educational evaluation?**

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**Areas of concern that may need further evaluation:**

\_\_\_ Academic    \_\_\_ Psychological    \_\_\_ Communication    \_\_\_ Developmental    \_\_\_ Behavioral    \_\_\_ Physical/Motor skills  
\_\_\_ Social/Emotional    \_\_\_ Assistive Technology    \_\_\_ Limited English Proficiency    \_\_\_ Other: \_\_\_\_\_

**Has the student previously received special education services?**

\_\_\_ Yes

Name of School: \_\_\_\_\_

Year: \_\_\_\_\_

\_\_\_ No

**Attendance:** Current Year: Days Absent \_\_\_\_\_ Days Tardy \_\_\_\_\_

**Has the student been retained in grade?**

Yes \_\_\_\_\_ Grade and Year: \_\_\_\_\_

No \_\_\_\_\_

**Is student passing all classes? If not, list classes currently failing:**

\_\_\_\_\_

**State standardized Achievement Test Results (Ex: Smarter Balanced; Include percentile rank)**

Year	Math	Reading	Writing

**Progress Monitoring Test Results (Ex: MAP, STAR, CBM; Include percentile rank)**

End of Previous School Year	Math	Reading/Language
Current School Year	Math	Reading/Language
Fall		
Winter		
Spring		

**List any behaviors that may have impacted results of standardized testing (Ex: Focus, task engagement, ill, etc.)**

\_\_\_\_\_  
\_\_\_\_\_

## CURRENT PERFORMANCE LEVELS

\_\_\_ ENGLISH: Complete Pages 4-5

\_\_\_ MATH: Complete Pages 6-7

\_\_\_ SCIENCE: Complete Page 8

\_\_\_ SOCIAL STUDIES / HISTORY: Complete Page 9

\_\_\_ ELECTIVE 1: \_\_\_\_\_ Complete Page 10

\_\_\_ ELECTIVE 2: \_\_\_\_\_ Complete Page 11

\_\_\_ ELECTIVE 3: \_\_\_\_\_ Complete Page 12

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### School Counselor Observations:

Frequency of contact: \_\_\_\_\_ times per \_\_\_\_\_ (day, week, month)

Progress:

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Needs:

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### Administrator Observations:

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**ENGLISH**    **Teacher Name:** \_\_\_\_\_    **Date:** \_\_\_\_\_

Please provide a description of strengths and weaknesses in the areas below and an estimate of the student’s instructional level.

<b>Reading:</b>
Mechanics (decoding, fluency/pace):
Reading Comprehension:
Quality of Class Participation/Discussion:
<b>Writing:</b>
Grammar/Punctuation/Spelling:
Generating Ideas:
Conveying Ideas in Writing/Meeting Assignment Requirements:

**EXECUTIVE SKILLS / LISTENING COMPREHENSION**

Mark with an “X” the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Starting /finishing tasks, turning in homework	<input type="checkbox"/> Behavioral / emotional self-control
<input type="checkbox"/> Distractible / daydreams	<input type="checkbox"/> Organization of materials / preparation for class
<input type="checkbox"/> Remembering directions / oral instruction	<input type="checkbox"/> Understanding rapid speech, says “What?” a lot
<input type="checkbox"/> Self-monitoring in a group	<input type="checkbox"/> Detecting innuendo, nonverbal communication

**EMOTIONS / BEHAVIOR**

Mark with an “X” the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Relationships with peers	<input type="checkbox"/> Anxious / nervous / agitated
<input type="checkbox"/> Relationships with adults	<input type="checkbox"/> Irritable / angry
<input type="checkbox"/> Defiant / problems with authority	<input type="checkbox"/> Bizarre behavior / hallucinations
<input type="checkbox"/> Verbal / physical aggression	<input type="checkbox"/> Sensory sensitivity (light, sound, texture)
<input type="checkbox"/> Sad, tearful, withdrawn	<input type="checkbox"/> Self-harm (cutting, scratching, head-banging)
<input type="checkbox"/> Tired / lethargic	<input type="checkbox"/> Has threatened to harm self or others

**Recommendations / Student Needs:**

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**Accommodations Provided:** (Example: Adjusted seating, copy of notes, audiobooks, text to speech/speech to text, scribe, extra time, alternate environment, breaks, open-note tests, repeat/clarify instructions, calculator, modified pace/move to Title 1 section, etc. ) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Interventions Provided:** (Example: Modification of Content, After-School Learning Center, Check & Connect, Intervention Curriculum, Replacement Curriculum, Extensive 1:1 Re-Teaching, IXL) \*Interventions from previous year may be included.

**INTERVENTION #1**

<p><input type="checkbox"/> Tier 1 (Whole class—applied to all students to create optimal learning outcomes)</p> <p><input type="checkbox"/> Tier 2 (Completed in addition to Tier 1 core instruction, typically small group, 20-30 min, 3-4 times/week)</p> <p><input type="checkbox"/> Tier 3 (Individualized to student, may include trial of core replacement program, typically 30+ min, 5 days/week)</p> <p><input type="checkbox"/> Outside Agency (Counseling, Medical, Tutoring, Mentoring, Inpatient, ABA, Speech, Occupational Therapy, etc.)</p> <p>Intervention: _____ _____</p> <p>Implemented by: _____</p> <p>Start Date: _____ End Date: _____</p> <p>Outcome (Include summary of progress monitoring data if available): _____ _____ _____</p>
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**INTERVENTION #2**

<p><input type="checkbox"/> Tier 1 (Whole class—applied to all students to create optimal learning outcomes)</p> <p><input type="checkbox"/> Tier 2 (Completed in addition to Tier 1 core instruction, typically small group, 20-30 min, 3-4 times/week)</p> <p><input type="checkbox"/> Tier 3 (Individualized to student, may include trial of core replacement program, typically 30+ min, 5 days/week)</p> <p><input type="checkbox"/> Outside Agency (Counseling, Medical, Tutoring, Mentoring, Inpatient, ABA, Speech, Occupational Therapy, etc.)</p> <p>Intervention: _____ _____</p> <p>Implemented by: _____</p> <p>Start Date: _____ End Date: _____</p> <p>Outcome (Include summary of progress monitoring data if available): _____ _____ _____</p>
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**Student Strengths** (ex: academic, personality trait, special skill, family or community support, interests):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MATH**

Teacher Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please provide a description of strengths and weaknesses within the areas below and an estimate of the student's instructional level.

<b>Overall Class Performance:</b>
<b>Math Reasoning/Conceptualization:</b>
<b>Math Calculation:</b>

**EXECUTIVE SKILLS / LISTENING COMPREHENSION**

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Starting /finishing tasks, turning in homework	<input type="checkbox"/> Behavioral / emotional self-control
<input type="checkbox"/> Distractible / daydreams	<input type="checkbox"/> Organization of materials / preparation for class
<input type="checkbox"/> Remembering directions / oral instruction	<input type="checkbox"/> Understanding rapid speech, says "What?" a lot
<input type="checkbox"/> Self-monitoring in a group	<input type="checkbox"/> Detecting innuendo, nonverbal communication

**EMOTIONS / BEHAVIOR**

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Relationships with peers	<input type="checkbox"/> Anxious / nervous / agitated
<input type="checkbox"/> Relationships with adults	<input type="checkbox"/> Irritable / angry
<input type="checkbox"/> Defiant / problems with authority	<input type="checkbox"/> Bizarre behavior / hallucinations
<input type="checkbox"/> Verbal / physical aggression	<input type="checkbox"/> Sensory sensitivity (light, sound, texture)
<input type="checkbox"/> Sad, tearful, withdrawn	<input type="checkbox"/> Self-harm (cutting, scratching, head-banging)
<input type="checkbox"/> Tired / lethargic	<input type="checkbox"/> Has threatened to harm self or others

**Recommendations / Student Needs:**


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**Accommodations Provided:** (Example: Adjusted seating, copy of notes, audiobooks, text to speech/speech to text, scribe, extra time, alternate environment, breaks, open-note tests, repeat/clarify instructions, calculator, modified pace/move to Title 1 section, etc. ) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Interventions Provided:** (Example: Modification of Content, After-School Learning Center, Check & Connect, Intervention Curriculum, Extensive 1:1 Re-Teaching, IXL) \*Interventions from previous year may be included.

**INTERVENTION #1**

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**INTERVENTION #2**

<p><input type="checkbox"/> Tier 1 (Whole class—applied to all students to create optimal learning outcomes)</p> <p><input type="checkbox"/> Tier 2 (Completed in addition to Tier 1 core instruction, typically small group, 20-30 min, 3-4 times/week)</p> <p><input type="checkbox"/> Tier 3 (Individualized to student, may include trial of core replacement program, typically 30+ min, 5 days/week)</p> <p><input type="checkbox"/> Outside Agency (Counseling, Medical, Tutoring, Mentoring, Inpatient, ABA, Speech, Occupational Therapy, etc.)</p> <p>Intervention: _____ _____</p> <p>Implemented by: _____</p> <p>Start Date: _____ End Date: _____</p> <p>Outcome (Include summary of progress monitoring data if available): _____ _____ _____</p>
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**Student Strengths** (ex: academic, personality trait, special skill, family or community support, interests):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# SCIENCE

CLASS NAME : \_\_\_\_\_

Title I \_\_\_ Yes \_\_\_ No

Teacher Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please provide a description of student's strengths and weaknesses within the areas below:

<b>Overall class performance:</b>
<b>Mastery of material:</b>

## EXECUTIVE SKILLS / LISTENING COMPREHENSION

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Starting /finishing tasks, turning in homework	<input type="checkbox"/> Behavioral / emotional self-control
<input type="checkbox"/> Distractible / daydreams	<input type="checkbox"/> Organization of materials / preparation for class
<input type="checkbox"/> Remembering directions / oral instruction	<input type="checkbox"/> Understanding rapid speech, says "What?" a lot
<input type="checkbox"/> Self-monitoring in a group	<input type="checkbox"/> Detecting innuendo, nonverbal communication

## EMOTIONS / BEHAVIOR

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Relationships with peers	<input type="checkbox"/> Anxious / nervous / agitated
<input type="checkbox"/> Relationships with adults	<input type="checkbox"/> Irritable / angry
<input type="checkbox"/> Defiant / problems with authority	<input type="checkbox"/> Bizarre behavior / hallucinations
<input type="checkbox"/> Verbal / physical aggression	<input type="checkbox"/> Sensory sensitivity (light, sound, texture)
<input type="checkbox"/> Sad, tearful, withdrawn	<input type="checkbox"/> Self-harm (cutting, scratching, head-banging)
<input type="checkbox"/> Tired / lethargic	<input type="checkbox"/> Has threatened to harm self or others

### Accommodations Provided:

(Example: Adjusted seating, copy of notes, audiobooks, text to speech/speech to text, scribe, extra time, alternate environment, breaks, open-note tests, repeat/clarify instructions, calculator, modified pace/move to Title 1 section, etc. )

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### Recommendations / Student Needs:

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# SOCIAL STUDIES / HISTORY

CLASS NAME : \_\_\_\_\_

Title I \_\_\_ Yes \_\_\_ No

Teacher Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please provide a description of student's strengths and weaknesses within the areas below:

<b>Overall class performance:</b>
<b>Mastery of material:</b>

## EXECUTIVE SKILLS / LISTENING COMPREHENSION

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Starting /finishing tasks, turning in homework	<input type="checkbox"/> Behavioral / emotional self-control
<input type="checkbox"/> Distractible / daydreams	<input type="checkbox"/> Organization of materials / preparation for class
<input type="checkbox"/> Remembering directions / oral instruction	<input type="checkbox"/> Understanding rapid speech, says "What?" a lot
<input type="checkbox"/> Self-monitoring in a group	<input type="checkbox"/> Detecting innuendo, nonverbal communication

## EMOTIONS / BEHAVIOR

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Relationships with peers	<input type="checkbox"/> Anxious / nervous / agitated
<input type="checkbox"/> Relationships with adults	<input type="checkbox"/> Irritable / angry
<input type="checkbox"/> Defiant / problems with authority	<input type="checkbox"/> Bizarre behavior / hallucinations
<input type="checkbox"/> Verbal / physical aggression	<input type="checkbox"/> Sensory sensitivity (light, sound, texture)
<input type="checkbox"/> Sad, tearful, withdrawn	<input type="checkbox"/> Self-harm (cutting, scratching, head-banging)
<input type="checkbox"/> Tired / lethargic	<input type="checkbox"/> Has threatened to harm self or others

### Accommodations Provided:

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### Recommendations / Student Needs:

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# ELECTIVE I

CLASS NAME : \_\_\_\_\_

Title I \_\_\_ Yes \_\_\_ No

Teacher Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please provide a description of student's strengths and weaknesses within the areas below:

<b>Overall class performance:</b>
<b>Mastery of material:</b>

## EXECUTIVE SKILLS / LISTENING COMPREHENSION

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Starting /finishing tasks, turning in homework	<input type="checkbox"/> Behavioral / emotional self-control
<input type="checkbox"/> Distractible / daydreams	<input type="checkbox"/> Organization of materials / preparation for class
<input type="checkbox"/> Remembering directions / oral instruction	<input type="checkbox"/> Understanding rapid speech, says "What?" a lot
<input type="checkbox"/> Self-monitoring in a group	<input type="checkbox"/> Detecting innuendo, nonverbal communication

## EMOTIONS / BEHAVIOR

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Relationships with peers	<input type="checkbox"/> Anxious / nervous / agitated
<input type="checkbox"/> Relationships with adults	<input type="checkbox"/> Irritable / angry
<input type="checkbox"/> Defiant / problems with authority	<input type="checkbox"/> Bizarre behavior / hallucinations
<input type="checkbox"/> Verbal / physical aggression	<input type="checkbox"/> Sensory sensitivity (light, sound, texture)
<input type="checkbox"/> Sad, tearful, withdrawn	<input type="checkbox"/> Self-harm (cutting, scratching, head-banging)
<input type="checkbox"/> Tired / lethargic	<input type="checkbox"/> Has threatened to harm self or others

### Accommodations Provided:

(Example: Adjusted seating, copy of notes, audiobooks, text to speech/speech to text, scribe, extra time, alternate environment, breaks, open-note tests, repeat/clarify instructions, calculator, modified pace/move to Title 1 section, etc. )

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### Recommendations / Student Needs:

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## ELECTIVE 2

CLASS NAME : \_\_\_\_\_

Title I \_\_\_ Yes \_\_\_ No

Teacher Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please provide a description of student's strengths and weaknesses within the areas below:

**Overall class performance:**

**Mastery of material:**

### EXECUTIVE SKILLS / LISTENING COMPREHENSION

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Starting /finishing tasks, turning in homework	<input type="checkbox"/> Behavioral / emotional self-control
<input type="checkbox"/> Distractible / daydreams	<input type="checkbox"/> Organization of materials / preparation for class
<input type="checkbox"/> Remembering directions / oral instruction	<input type="checkbox"/> Understanding rapid speech, says "What?" a lot
<input type="checkbox"/> Self-monitoring in a group	<input type="checkbox"/> Detecting innuendo, nonverbal communication

### EMOTIONS / BEHAVIOR

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Relationships with peers	<input type="checkbox"/> Anxious / nervous / agitated
<input type="checkbox"/> Relationships with adults	<input type="checkbox"/> Irritable / angry
<input type="checkbox"/> Defiant / problems with authority	<input type="checkbox"/> Bizarre behavior / hallucinations
<input type="checkbox"/> Verbal / physical aggression	<input type="checkbox"/> Sensory sensitivity (light, sound, texture)
<input type="checkbox"/> Sad, tearful, withdrawn	<input type="checkbox"/> Self-harm (cutting, scratching, head-banging)
<input type="checkbox"/> Tired / lethargic	<input type="checkbox"/> Has threatened to harm self or others

### Accommodations Provided:

(Example: Adjusted seating, copy of notes, audiobooks, text to speech/speech to text, scribe, extra time, alternate environment, breaks, open-note tests, repeat/clarify instructions, calculator, modified pace/move to Title 1 section, etc. )

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### Recommendations / Student Needs:

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### ELECTIVE 3

CLASS NAME : \_\_\_\_\_

Title I \_\_\_ Yes \_\_\_ No

Teacher Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please provide a description of student's strengths and weaknesses within the areas below:

<b>Overall class performance:</b>
<b>Mastery of material:</b>

#### EXECUTIVE SKILLS / LISTENING COMPREHENSION

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Starting /finishing tasks, turning in homework	<input type="checkbox"/> Behavioral / emotional self-control
<input type="checkbox"/> Distractible / daydreams	<input type="checkbox"/> Organization of materials / preparation for class
<input type="checkbox"/> Remembering directions / oral instruction	<input type="checkbox"/> Understanding rapid speech, says "What?" a lot
<input type="checkbox"/> Self-monitoring in a group	<input type="checkbox"/> Detecting innuendo, nonverbal communication

#### EMOTIONS / BEHAVIOR

Mark with an "X" the areas in which the student has unusual difficulty compared to peers:

<input type="checkbox"/> Relationships with peers	<input type="checkbox"/> Anxious / nervous / agitated
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<input type="checkbox"/> Defiant / problems with authority	<input type="checkbox"/> Bizarre behavior / hallucinations
<input type="checkbox"/> Verbal / physical aggression	<input type="checkbox"/> Sensory sensitivity (light, sound, texture)
<input type="checkbox"/> Sad, tearful, withdrawn	<input type="checkbox"/> Self-harm (cutting, scratching, head-banging)
<input type="checkbox"/> Tired / lethargic	<input type="checkbox"/> Has threatened to harm self or others

#### Accommodations Provided:

(Example: Adjusted seating, copy of notes, audiobooks, text to speech/speech to text, scribe, extra time, alternate environment, breaks, open-note tests, repeat/clarify instructions, calculator, modified pace/move to Title 1 section, etc. )

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#### Recommendations / Student Needs:

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**ADDITIONAL INFORMATION**

**Please provide any additional information relevant to the referral and evaluation** (Example: Interventions not listed elsewhere, previous services and placements, social or medical information, information supplied by parent/guardian):

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**Printed name of person making referral:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of person making referral:** \_\_\_\_\_ **Parent** **District**

The public agency shall give the parent/guardian a copy of the Referral for Comprehensive Evaluation document at no cost to the parent/guardian.