Lyon County Schools
SPECIAL EDUCATION REFERRAL FORM

Student's Full Name:	
Date of Birth: Grade: School:	
Primary Mode of Communication of the Student:	
Student Represented by: _ Parent _ Guardian _ Self _ Surrogate	
Does Student Live with Parents: _ Yes _ No	
If no, with whom does the student live? Relationship:	
Parent/Guardian:	
Home Address:	
Home Phone:	Cell Phone:
Primary Mode of Communication in the Home:	
General Education Teacher:	Referring Person/Title:

Summary of Interventions
Describe the areas being targeted for intervention and means of identifying:
Indicate the area(s) of suspected disability (interventions must match deficit areas of suspected disability):
Concerns with fidelity of implementation were observed in the following areas **(yes or no):** Tier I (Core Instruction)? ☐ Yes ☐ No Tier II? ☐ Yes ☐No Tier III? ☐ Yes ☐ No

If "yes" to any areas, please explain:

Describe the parental involvement in the data sharing and decision making process:

Additional Comments:

Describe the Tier III intervention(s) implemented in the general education classroom to address the area being targeted and the name of the interventionist.

Intervention and Interventionist	Dates		Frequency of Service	Amount of Time	Impact (What was the end result? What the final level/score?)	Expected Progress (Where should the student have been at the end of this intervention?)
	Begin	End				

Major Area(s) of Concern

Communication:

_ Communicates Basic Needs and Wants
_ Knowledge of Sound/Letter Association
_ Receptive Language
_ Other (Specify):
_ Articulation
_Expressive Language
_Voice Quality

Academic Performance

_ Oral Expression
_ Reading Comprehension
_ Listening Comprehension
_ Reading Fluency
_ Other (Specify):
_ Written Expression
_ Mathematics Calculation
_ Basic Reading Skills
_ Mathematical Reasoning and Application

Health, Vision, Hearing, and Motor Abilities

_ Gross Motor Skills: Body Control
_ Vision
_ Fine Motor Skills: Perceptual Motor
_ Hearing
_ Other (Specify):

_ Gross Motor Skills: Locomotion
_ Developmental History
_ Fine Motor: Sensory

Social and Emotional Status

_ Interaction with Peers
_ Acceptance of Rules
_ Acceptance of Disappointment
_ Team Memberships
_ Repetitive Behaviors
_ Inactivity or Withdrawal
_ Self Control
_ Other (Specify):

_ Interaction with Adults
_ Acceptance of Correction
_ Self Help Skills/Play Skills
_ Mood Swings
_ Self Concept
_ Cooperation
_ Expression of Feeling/Affect

General Intelligence

_Understanding New Concepts
_Interpreting Data to Make Decisions
_ Perceptual Discrimination
_ Problem Solving
_ Memory
_ Other (Specify):

_Interpreting New Concepts
_Comparing/Contrasting Ideas of Objects
_ Predicting Events/Results
_ Applying Knowledge

Work Skills/Technical/Vocational Functioning

_ Attending to Task
_ Independent Work Habits
_ Using Research Tools Effectively
_ Having Realistic Vocational Goals
_ Completing Work
_ Organizing Materials/Belongings
_ Identifying Preferences/Interest
_ Other Specify:

_ Following Directions
_ Seeking Assistance
_ Maintaining Physical Stamina
_ Punctuality
_ Completing Work
_ Using Technology to Gather/Organize Info
_ Recognize Personal Limitations

School Information

Number of Schools Attended to Date:

Year/Grade	Days Enrolled	Excused absences (#)	Unexcused absences (#)	Excused tardies (#)	Unexcused tardies (#)

Years in School, Including Current Year(# of years in grades 4-12)	Years in Primary Program, Including Current Year (# of years in grades K-3)	Repeated Grades:

Summary of Most Recent Grades					
Reading		English		Other:	
Spelling		Science		Other:	
Math		Social Studies		Other:	

Physical Functioning (attach documentation for results of each screening)			
Vision	Hearing	Motor	Speech
Required documentation for students referred for special education.		*Required when SLD suspected /determined by ARC.*	*Required as Determined by ARC*
Screening Date:	Screening Date:	Screening Date:	Screening Date:
Passed _ Failed _	Passed _ Failed _	Passed _ Failed _	Passed _ Failed _
Describe any Existing Medical Health Conditions Below:			
Is Student Currently on Medication (Specify Type and Dosage)			

Summary of Past and Present Support
Has this student been evaluated for special education previously?
If yes, When was the student evaluated? What was the suspected area of disability?

What services is this student receiving or what services has this student received in the past? For the services below enter C if currently receiving or P if the service was provided in the past.						
Limited English Proficient	Migrant	Title 1	Speech Language	504	Extended School Services	Gifted and Talented
Involvement with Outside Agency(ies)?						
Describe services that are being provided to this student by agency(ies) listed above:						

Documentation of Student Progress: Scores from District Universal Screenings								
Test:	Reading:							
Test:	Math:							
Test:	Behavior:							
Test:	Writing:							