REFERRAL FOR PLAY-BASED SCREENING

CHILD'S INFORMATION

NAME: ____________________

STREET: ____________________

CITY: ____________________

GRADE: ____________________

STATE/ZIP: ____________________

DATE OF BIRTH: ____________________

GENDER: ____________________

Student's native language (if not English): ____________________

PARENTS' / GUARDIAN INFORMATION

NAME(s): ____________________

STREET: ____________________

CITY: ____________________

STATE/ ZIP: ____________________

HOME PHONE: ____________________

WORK PHONE: ____________________

CELL PHONE: ____________________

EMAIL: ____________________

Parent's native language (if not English): ____________________

Reason for Referral:

____

____

____

EDUCATIONAL HISTORY

Provide data about the child's growth and development:

____

____

____

Provide data from previous interventions/ early interventions, community or preschool providers:

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____

____

List schools/early childhood programs and dates:

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____

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with Vision/ Hearing:

Does the student Wear Glasses /Use hearing aid(s):

Does the student take medication: If yes, specify type and purpose:

Does the student have any health/developmental/physical problems of which you are aware? If yes, please explain:

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school:

Please check any area(s) of concern:

Eating ___
Dressing ___
Toileting ___
Attention___
Receptive Communication ___
Expressive Communication ___
Hearing____
Cognitive ___
Fine Motor ___
Play___
Gross Motor___
Vision ____
Social/Emotional Behavior___
Other____

Describe any other pertinent information not previously described:

____
____
____

SIGNATURES

Signature of Person Initiating the Referral____________________________________
Position or Relationship to Student____
Date____________________

Signature of Person Receiving the Referral_______________________
Title______________________________
Date Received____________________________
Date District Suspects a Disability________________________

School use only:

Follow- up notes:____
____
____
____
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