

REFERRAL FOR SPECIAL EDUCATION SERVICES

Date Referral Completed

Date District Special Education Office Received

--	--

Referral Initiated by

	Name(s):
--	----------

Student Information

Name		Gender	
DOB		Age	
Grade		School	

Parent / Caregiver #1

Name		Phone	
Street		Town	
Email			

Parent / Caregiver #2

Name		Phone	
Street		Town	
Email			

Reason for Referral

--

Parent Input

Student Strengths / Positives	
Concerns	
Other	

*****If a parent referral, please stop here and return form to the school*****

Parent Contact Regarding Referral

Date		Method of Contact	
Other Information Provided			

Previous referral to special education?

If yes, were special education services previously received:
If yes, date and qualifying eligibility category:

Vision & Hearing

Hearing	Date:	Result
Vision	Date:	Result

Student Attendance:

Current Year	Absent:	Tardy:	Dismissals:
Previous Year	Absent:	Tardy:	Dismissals:

Student's Strengths

--

Student Concerns

--

Recent Class Assessments/Grades/Homework Completion Percentage

--

District-wide Assessments/Performance Levels:

Assessment:	Date:	Performance Level:	Additional Information/Comments:

Supporting Documents Attached:			

Targeted Pre-Referral Interventions / Supports

Service Description:	Date of Initiation:	Duration and Frequency:	Student Response:
Supporting Documents Attached:			

Other factors relevant to this referral

--

Staff members that support this student and should be invited to an initial IEP meeting

--

Attached Documents

	RTI Profile
	SCT Notes
	NWEA Student Progress Report
	Other:
	Other:

Principal

Signature	Date

Special Education Staff Receiving this Referral

Signature	Date

Director of Special Education

Signature	Date

APPROVED **DENIED**

<input type="checkbox"/> Insufficient Documentation: <input type="checkbox"/> Other:

****Please attach relevant work samples and copies of most recent district-wide and/or diagnostic assessments, as appropriate to support this referral.***