Thief River Falls Public Schools
Referral for EL Services

Student name: ______________________________________ Grade: ______________

Age: _______________________ Date of Birth: ________________________________

Reason for referral:

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Has student received any Special Education services? ( ) Yes ( ) No
If yes, which area(s): ____

Assessment data: Please list testing and results if any has been done.

Reading: ____

Language: ____

Standardized Test: ____

Other: ____

Referring Teacher: ____

Building: ____

PLEASE RETURN TO KATE ANDERSON AT LHS OR JADE HAUGEN AT FMS & CES