WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION DEPARTMENT

VISION AND HEARING REFERRAL

Student: _____ Birth Date: _____ Grade: _____

School: _____ Sp.Ed.Program: _____ Room: _____

❒ Initial Evaluation ❒ Three-Year Evaluation

Date of Signed Assessment Plan: _____

IEP Meeting Date (if known): _____

Psychologist or Speech: _____

Pertinent information you would like us to be aware of: _____

_____

_____

_____

Vision Screening Results:

Right Eye: 20/_____ Left Eye: 20/_____

Comments:

Date: _____ Screener: _____

Hearing Screening Results:

	500	1000	2000	4000	6000
Right Ear:					
Left Ear					

Comments:

Date: _____ Screener: _____

Directions for use: Psychologist completes upper portion of Referral Form and forwards to Nurse, who screens the student and returns form with results to Psychologist.

Distribution: • White-Sp.Ed. File • Yellow – Psych. or Speech • Pink – Receiving School