



# Grandview School District Special Education REFERRAL FORM

Name of Student:

Grade:

Age:

Birth Date:

Sex (check one)  Male  Female

Referred by:

Date of referral:

School:

Teacher:

Sign Language/Interpreter Needed?  Yes  No

Home Language:

Parents prefer written communications in:  English  Spanish  Other:

Parent/Guardian Name:

Parent/Guardian Name:

Mother/Guardian Name

Father/Guardian Name

Parent Address:

Phone:

Cell:

Date Parents Notified:

Parent(s) will attend meeting:  Yes  No

Permission to proceed with meeting if unable to attend:  Yes  No

Surrogate Needed?  Yes  No Name:

### Prior Services:

Please list any prior services (i.e. counseling, therapy) the student has received that you know of, including dates:

What was the outcome from these services?

When did this student enter Grandview School District?

Was there a previous Special Education referral?  Yes  No When?

What was the outcome?

Attendance: (days absent this school year) Did this student start school late, or have any significant school interruption?

Instructional Program:  Dual Language  English Only  Both

ELL  Yes  No If yes what ELL level:

What would you like to gain from this staffing?

Give a brief description of your concern(s). Please indicate if previous teacher noted this concern.

Academics:

Social / Emotional:

Adaptive (self-care / "common sense"):

Physical (fine / gross motor):

**SPEECH AND / OR LANGUAGE CONCERNS (check all that apply):**

- Unusual Voice quality (pitch, hoarseness, loud / weak voice, etc...)
- Stuttering (hesitation, repetition of words, evidence of struggle when speaking)
- Inappropriate use of language (incomplete sentences, limited vocab, incorrect word order...)
- Limited language comprehension (trouble following directions, off-target responses to questions)
- Errors in speech sounds

**Specific language concern:****Examples of student's speaking deficits:****Adverse impact on education:****What strategies and interventions have already been provided to meet the needs of the student?**

Strategy / Intervention	Frequency	Length	Results

**Testing Data: Complete as many areas as possible, fill in blanks if needed**

Test	Area	Score / Level / Unit	Grade Level Expectation	Comments
<b>STATE</b>				
	<b>Reading</b>			
	<b>Math</b>			
	<b>Writing</b>			
	<b>Science</b>			
<b>Other benchmark assessments</b>				
	<b>Reading</b>			
	<b>Math</b>			
	<b>Writing</b>			
	<b>Reading</b>			
	<b>Math</b>			
	<b>Writing</b>			

**After reviewing this referral, the following decision has been made by the School District:**

- Seek consent to provide a Special Education evaluation for this student.
- A Special Education evaluation would not be appropriate at this time. There is not adequate evidence to suspect a disability which would adversely affect academic performance - with or without accommodations.
- PWN attached to referral form if not proceeding with evaluation.

**School Psychologist's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Principal Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Required Health Information Collected for Special Education Referral and Re-evaluations**

**Name of Student:**

**Grade:**

**Age:**

**Birth Date: Sex (check one)  Male  Female**

**Referred by:**

**Date of Referral:**

**Nature of concern: Teacher:** \_\_\_\_\_

**Completed by School Nurse:**

**SUMMARY OF EXISTING INFORMATION:** Prior referral to building specialists:

**Date(s):**

**Concerns:**

**Outcomes:**

**Physical/medical – Date:**

**Result:**

**SCREENING INFORMATION - Health Screening (attach developmental history, if appropriate)**

**Vision: Date:** \_\_\_\_\_

BOTH	RIGHT	LEFT
WO 20/	WO 20/	W O 20/
W 20/	W 20/	W 20/

**Hearing: Date:**

**A/C:**

**B/C:**

	250	500	1000	2000	4000	8000
<b>R</b>						
<b>L</b>						

**Specific health Concerns:**

**Other screening results:**