REFERRAL FOR EVALUATION

Student Name: _____ Date of Birth: _____ Grade: _____

Date Referral was initiated: _____ School: _____

Parents/Guardians/Surrogates: _____ Teacher: _____

Address: _____

Home Phone: _____ Primary Language of Student: _____ Family: _____

If Student or Family Language is other than English, attach the completed Referral and Evaluation of Language Minority Students for Special Education Checklist.

1. REFERRED BY (Check one and list name(s) below): ☐ GEI Team ☐ Parent ☐ Other: _____

Name	Title

Has a previous evaluation been conducted? ☐ Yes ☐ No

By whom? _____ Date: _____

Have results been requested? ☐ Yes ☐ No

2. Is this student currently receiving:

Special Education Services (Including Speech/Language Therapy) ☐ Yes ☐ No

Related Services (OT, PT, etc.) ☐ Yes ☐ No

If so, please specify:

3. Attendance

Days Present Current School Year	Unexcused Absences Current School Year	Excused Absences Current School Year	Days Suspended Current School Year	Tardies Current School Year

4. Describe each evaluation procedure, assessment, record, report, and any other factor used as a basis for proposing (or refusing) this referral for evaluation:

5. SCREENING RESULTS (must have occurred within the past six (6) months):

VISION	Screen date	Right Eye	Left Eye	Comments

HEARING	Screen date	Right Ear	Left Ear	Comments

STOP *If the student has failed the vision and/or hearing screening, a medical statement is recommended. Submit any medical results/recommendations to the evaluation team.*

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