Special Education Referral Form

☐ Initial

☐ Re evaluation

Current Eligibility_____

Service Plan _____

Date: _____

Student's FULL Name: _____
First Middle Last

Name Student goes by:_____ DOB: _____

School: _____ Grade: _____

Parent/Guardian _____

Address: _____ Phone: _____

Primary Language: _____

GTID #_____

Date the child was first referred to Tier 3/SST: _____

Describe academic and/or behavioral issues leading to referral: _____

_____

Has the child attended (or is the child attending) a preschool, Pre-K or Head Start program? ☐ No OR ☐ Yes

If so, what school? _____

Is this child age appropriate for this grade level? _____ If no, why?

☐ Retained _____ Grade ☐ Held out of school by parents

☐ Started school late ☐ Other _____

Did they pass hearing screening? ☐ Yes OR ☐ No Date of test: _____

Did they pass vision screening? ☐ Yes OR ☐ No Date of test: _____

If no on hearing or vision screening, please explain):

Does this student wear glasses? ☐ **Yes OR** ☐ **No** **Does this student wear hearing aids?** ☐ **Yes** ☐ **No**

Does the child have significant health concerns, major childhood illness/disease, or a diagnosed syndrome? (ADHD, seizures, diabetes, etc.)

_____

_____

Does the child take medication on a regular basis? ☐ **No OR** ☐ **Yes If so, please explain** _____

_____

_____

Does the child have motor/coordination/mobility needs? ☐ **No OR** ☐ **Yes If yes, please explain** _____

_____

_____

Does the child have adaptive or medical needs? ☐ **Eye glasses** ☐ **Wheel chair** ☐ **Walker**

☐ **Hearing aids** ☐ **Leg braces** ☐ **Feeding tube** ☐ **Other** _____

_____

Does the child have significant issues not covered in previous questions? ☐ **No OR** ☐ **Yes If yes, please explain:**

_____

_____

Has child been referred to school counselor? _____

Does child currently receive private therapy, tutoring, etc? ☐ **No OR** ☐ **Yes**

If yes, what kind and for how long?_____

Is child significantly inattentive, off-task, disruptive? ☐ **No OR** ☐ **Yes**

FORM DD2

Describe problematic behaviors:
(Check all that apply)

Reading:

_____Limited Vocabulary
_____Comprehension
_____Substitutions
_____Letter/Sound Relationships
_____Word Attack
____Reversals
____Letter Recognition
____Other:_____

Math:

_____Computational Skills: Add
_____Computational Skills: Multiply
_____Money Skills
_____Measurement
_____Counting
_____1:1 Correspondence
_____Computational Skills: Subtract
_____Computational Skills: Divide
_____Time
_____Place Values
_____Number Recognition
_____Other:_____

Written Expression:

_____Vocabulary
_____Grammatical Usage
_____Thematic Maturity
_____Sentence Structure

_____Other:_____

Oral Expression:

_____Grammatical Usage
_____Vocabulary
_____Sequencing Ability
_____Thematic Maturity
_____Sentence Structure

_____Other:_____

Listening Skills:

_____Attends
_____Follows directions

_____Comprehends
_____Other:_____

Organization:

_____Manages Time
_____Manages Materials

_____Follows Routine
_____Other:_____

Motor Skills: (Fine Motor)

_____Legible and Age Appropriate Handwriting
_____Manipulating Classroom Materials
_____Other:_____

Motor Skills: (Gross Motor)

_____ Traveling Independently: Safely Indoors

_____Traveling Independently: Outside Independently

_____Changing Seating

_____Other: _____

Daily Living:

_____ Eating Skills

_____Toileting Skills

_____Dressing Skills

_____Other:_____

Medical:

_____Hearing _____Vision

_____Medication _____Positioning

_____Allergies/Prescriptions _____Absence due to Illness

_____Other: _____

Communication:

_____Receptive Language _____Expressive Language

_____Articulation _____Voice

_____Fluency

Other:_____

If communication deficits are present, has SLP been consulted? ☐ Yes ☐ No

Student's Strengths:

_____

_____

_____

RTI Data

Intervention	Frequency	Dates

Attendance

Absences: **Previous Year _____** **Tardies:** **Previous Year _____**

Current Year _____ **Current Year _____**

Early Pick-Ups **Previous Year _____**

Current Year _____

Results of District, State & Benchmark Assessments such as:

GKIDS _____ CRCT _____ Practice CRCT _____ EOCT _____

Benchmarks _____ BLT _____

STAR (Data Attached) _____ Lexia (Data Attached) _____ Progress Monitoring (Data Attached) _____

Other: _____

Form completed by: _____ Date completed: _____

_____

Principal's Signature **Date**

Date sent to BOE: _____

Date received at BOE: _____ by _____

FORM DD5