

# Evaluation Referral Form

Type of Referral: Initial - 3-Year - Annual

Date:

To:

From:

Student Name:

Date of Birth:

Grade:

Parent/Guardian:

Address:

Phone:

Email:

Primary Language: Student - Parent/Caregiver -

Class Teachers:

Special Education Teacher:

## Background Referral Information

Who referred this student for an evaluation:

Has the student been evaluated for special education before?

Date of Evaluation?

Does the student have a disability? Yes/No - If yes, please list:

Which of the following regular education services does the student receive?

- Title 1 Reading       Title 1 Math       Counseling       ELL       504       Other:

## Evaluations Requested: (please check or bold)

- |   |   |
|---|---|
| <input type="checkbox"/> Educational                | <input type="checkbox"/> PT Evaluation                      |
| <input type="checkbox"/> Psychological Evaluation   | <input type="checkbox"/> OT Evaluation                      |
| <input type="checkbox"/> Classroom Evaluation       | <input type="checkbox"/> Bilingual Speech Evaluation        |
| <input type="checkbox"/> Observations               | <input type="checkbox"/> Bilingual Psychological Evaluation |
| <input type="checkbox"/> Home Assessment            | <input type="checkbox"/> Assistive Technology Evaluation    |
| <input type="checkbox"/> Speech Language Evaluation | <input type="checkbox"/> Health                             |

## What is the reason for the referral?

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## Suspected Area of Disability

What are the student's suspected areas of disability OR areas the student is having trouble? (check or bold all that apply)

- |                                     |   |                                    |                                    |
|-------------------------------------|---|------------------------------------|------------------------------------|
| <input type="radio"/> Autism        | <input type="radio"/> Dev. Delay                | <input type="radio"/> Sensory      | <input type="radio"/> Neurological |
| <input type="radio"/> Emotional     | <input type="radio"/> Physical                  | <input type="radio"/> Intellectual | <input type="radio"/> Health       |
| <input type="radio"/> Communication | <input type="radio"/> Specific Learning: (list) |                                    |                                    |

## Referral Concerns in a School Setting:

- |                |                                       |                               |  |
|----------------|---------------------------------------|-------------------------------|--|
| Academic Areas | <input type="radio"/> Math            | <input type="radio"/> Reading | <input type="radio"/> Calculations     |
|                | <input type="radio"/> Problem Solving | <input type="radio"/> Fluency | <input type="radio"/> Written Language |
|                | <input type="radio"/> Other: (List)   |                               |  |

- |               |                                       |                                      |                                    |
|---------------|---------------------------------------|--------------------------------------|------------------------------------|
| Related Areas | <input type="radio"/> Expressive/Oral | <input type="radio"/> Listening Comp | <input type="radio"/> Articulation |
|               | <input type="radio"/> Gross Motor     | <input type="radio"/> Fine Motor     | <input type="radio"/> Sensory      |
|               | <input type="radio"/> Other:          |                                      |                                    |

- |           |   |   |  |
|-----------|---|---|--|
| Cognitive | <input type="radio"/> Impulsive               | <input type="radio"/> Inattentive                 | <input type="radio"/> Weak Memory                  |
|           | <input type="radio"/> Disorganized            | <input type="radio"/> Difficulty with Transitions | <input type="radio"/> Inconsistent Academic Effort |
|           | <input type="radio"/> Restless or Hyperactive | <input type="radio"/> Difficulty with Rules       | <input type="radio"/> Difficulty with Routines     |
|           | <input type="radio"/> Other:                  |   |  |

- |         |   |   |
|---------|---|---|
| Conduct | <input type="radio"/> Fights Frequently at School   | <input type="radio"/> Defines Authority             |
|         | <input type="radio"/> Verbally Aggressive to Adults | <input type="radio"/> Physically Aggressive         |
|         | <input type="radio"/> Verbally Aggressive to Peers  | <input type="radio"/> Destroys School/Peer Property |
|         | <input type="radio"/> Other:                        |   |

- |                  |  |   |
|------------------|--|---|
| Social/Emotional | <input type="radio"/> Withdrawn                  | <input type="radio"/> Nervous/Tense             |
|                  | <input type="radio"/> Worries/Expresses Fears    | <input type="radio"/> Appears Angry             |
|                  | <input type="radio"/> Mood Fluctuations          | <input type="radio"/> Seems Unmotivated         |
|                  | <input type="radio"/> Behavioral Outbursts       | <input type="radio"/> Unusual Behavior          |
|                  | <input type="radio"/> Physical Complaints        | <input type="radio"/> Looks Sad or Depressed    |
|                  | <input type="radio"/> Limited Peer Relationships | <input type="radio"/> Difficulty w/ Frustration |
|                  | <input type="radio"/> Other:                     |   |

## Areas of Strength:

# Evaluation Referral Form

**Other Concerns or Additional Information:**

Person Completing this Form: \_\_\_\_\_

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Consent Received (Date):

30 Day Eval Due:

45 Day Meeting Due:

Date of TEAM Meeting (if known):