

SCHOOL REFERRAL FOR ESU 8 PSYCHOLOGICAL AND/OR SPEECH/LANGUAGE SERVICES (School Age)

This child has been referred for special services and/or evaluation. Information from school personnel and parents is equally important in gaining a full understanding of this child. **Please answer all questions as completely as possible** (even in the case of reevaluation).

Name of School: _____ Name of person making referral: _____

Contact Person: _____ Email address: _____ Phone # _____

I. Background Information

Student Name: _____ DOB: _____ Age: _____ Grade: _____

Gender Assigned at Birth: M ☐ F ☐

Gender Identifying as: M ☐ F ☐

Mother's name: _____ Occupation: _____ Phone: _____

Father's name: _____ Occupation: _____ Phone: _____

Email: _____

Best time to reach parent: _____

Method(s) of communication school has used with parent(s): Call ☐ Text ☐ Email ☐

II. School Information

Why is this student in need of evaluation and/or services (current concerns)?

Has the student previously been evaluated outside of the school district? Yes or No

If Yes, please enclose a copy of the previous evaluation results.

Has the student ever been under the ongoing care of a physician or mental health professional for physical, emotional, behavioral, or other reason? If **yes**, what condition:

If the student is taking any prescribed medications or herbal remedies, please list the name and what it is for.

Prior school(s) attended _____ Dates _____ Grades: _____

Has the student ever been retained? Yes or No If **yes**, grade level: _____

Date of Visual Test/Screening _____ Results _____ Glasses or contacts? Yes No

Date of Hearing Test/Screening _____ Results _____ Hearing Aids? Yes No

III. Schedule and Grades***Class Schedule and current grades may be attached**

Core

Teacher _____ (name) _____	Subject _____	Current Grade _____ (letter or %) _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Intervention History

List all intervention or services the student has received **in the past** (e.g., EIR, Corrective B1, speech/language, behavior intervention chart, small group counseling, physical therapy):

List the student's **current** intervention(s), including amount of time per week (e.g., EIR in resource 50 min/day):

Is the student meeting grade level expectations? Yes No

***Please attach district assessment results** (e.g., MAP, NSCAS, Universal Screening)

What are the student's STRENGTHS (Academic, Behavioral, Social, Communication):

What are the student's NEEDS (Academic, Behavioral, Social, Communication):

Explain any additional concerns you have:

Please attach the following to this referral:

1. Signed Notice of Consent for Evaluation (SRS form) *Required for all
2. Parent Information Form *Required for all
3. Class Schedule *Required for all
4. Student Assistance Team Report (*For **INITIAL** evaluation only)
5. Copies of previous school evaluations not completed in your district
6. Copies of outside agency evaluations

Signature of person making the referral: _____ Position _____
Date _____

Signature of Authorized School Official: _____ Position _____
Date _____