

ENTIAT SCHOOL DISTRICT #127

2650 Entiat Way - Entiat, Washington 98822 – Telephone (509) 784-1800 – Fax (509) 784-2986 www.entiatchools.org

PURPOSE: The purpose of this form is to review information regarding a student who has already been referred and to make a decision whether to evaluate the student for special education services.

REVIEW OF REFERRAL FOR SPECIAL EDUCATION EVALUATION

Student name: _____ Date district received referral: _____
 Student ID #: _____ Birth date: _____ Grade: _____ Age: _____
 Home School: _____ Gender: _____
 Race/Ethnicity: _____ Primary Language in Home: _____
 Parent/Guardian Name(s): _____ E-mail address: _____
 Address: _____ City/State/Zip: _____
 Home Phone: _____ Work Phone: _____
 Is a surrogate parent needed? Yes No If yes, follow procedures for appointing a surrogate.
 Person who made referral: _____ Position/Role: _____

REASON FOR REFERRAL <i>(check all that apply):</i>	
<u>Instructional Concerns</u>	<u>Behavioral Concerns</u>
<input type="checkbox"/> Pre-literacy skills	<input type="checkbox"/> Attention and concentration
<input type="checkbox"/> Basic reading skills	<input type="checkbox"/> Non-compliance with teacher directives
<input type="checkbox"/> Pre-numeracy skills	<input type="checkbox"/> Following directions
<input type="checkbox"/> Basic math skills	<input type="checkbox"/> Easily frustrated
<input type="checkbox"/> Written language skills	<input type="checkbox"/> Extreme mood swings
<input type="checkbox"/> Cognitive learning strategies	<input type="checkbox"/> Social/peer interaction skills
<input type="checkbox"/> Communication skills	<input type="checkbox"/> Adaptive behavior skills
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> No instructional concerns noted	<input type="checkbox"/> No behavioral concerns noted

Review of Medical Information/Records *(describe any medical concerns currently impacting the student. Consider whether the student has any medical diagnoses, if the student is currently taking any medication at school and/or at home, is the student currently using any assistive technology devices, does the student wear glasses, does the student wear a hearing aid, etc.):*

Pre-referral Interventions *(describe any current or past supplemental programs/services or interventions provided to the child, such as Title 1, early intervention services, preschool, individualized interventions, etc. Describe any scientific research-based interventions implemented and the results.):*

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Educational History *(describe the student's educational history, including appropriate instruction in reading and math and the student's response, school attendance/absences, whether the student has ever repeated a grade, the student's English proficiency level and how it was determined, current performance levels in academic and/or functional areas (primarily those areas of concern), any home/environmental factors that might affect the student's performance in school, whether the student has been previously referred for special education services, etc.):*

Other Relevant Information *(describe any other relevant information from the parent, school, other agencies, etc.):*

Referral Team Recommendations:

- Special education evaluation recommended *(parent receives Prior Written Notice and Consent for Evaluation)*.
- Special education evaluation not recommended at this time *(parent receives Prior Written Notice)*.

Other Referral Team Recommendations:

Referral Team Members (including parent(s)):

Name	Position/Title

****Procedural Safeguards notice must be provided to parent upon initial referral.****