RSU #19

Special Services Department

P.O. Box 40

182 Moosehead Trail

Newport, ME 04953

Confidential Information

REFERRAL TO DETERMINE DISABILITY AND ELIGIBILITY FOR SPECIAL SERVICES

Please be sure to complete entire form and return to Special Services

A. **Student's Name:**_____ **D.O.B.:**_____ **Grade:** _____

School:_____ **Retained:** ___ **Yes** ___ **No** **Grade Retained:** _____

Parent(s)/Guardian(s): _____

Address: _____

Telephone Number: _____

Specific area(s) of concern: _____

_____

_____

_____

_____

Expected GLS in area(s) of concern: _____

_____

_____

(attach most recent assessments)

Student received "Alternative Programming" (i.e. K-1 transition, half-day, hrs/day, etc) :

_____

Referred by: _____ **Position/Title:** _____

Attendance: ___ **Acceptable** ___ **Unacceptable**

B. Health Information Section - Must be completed by School Nurse

Hearing Screening: ____Pass ____Fail Date: _____.

Vision Screening: ____Pass ____Fail Date: _____.

Wears Glasses: ____ Yes ____ No Date: _____.

Comments: _____

_____

_____

Health Information Section Continued:

Has Poly Tubes: ____Yes (R-ear --- L-ear) _____No (R-ear --- L-ear)

Comments: _____

Wears Hearing Aid: ____ Yes (R-ear --- L-ear) ____ No (R-ear --- L-ear)

Comments: _____

Is this student on medication? ___Yes ___No

Name of Medication(s): _____

Possible Side Effects: _____

General Health Comments: _____

_____

_____

_____

_____

C. OTHER REFERRAL INFORMATION

The student has shown signs that lead me to suspect the following disability: Please circle one or more of the following):

Intellectual Disability	Hearing Impairment	Emotional Disability
Orthopedic Impairment	Specific Learning Disability	Speech/Lang. Impairment
Traumatic Brain Injury	Deaf	Autism
Deaf/Blind		
Visual Impairment/including Blindness	Other Health Impairment	Multiple Disabilities

D. Describe the lack of progress in **specific** academic areas leading up to this referral:

_____

_____

_____

_____

E. Describe the alternative actions, including your classroom accommodations and scientifically research-based instructional method you have tried and the reasons they were not successful. Attach documentation reflecting data based on intervention used. **Note: A minimum of two (2) interventions/strategies must be tried with at least 6 weeks per intervention/strategy used.)**

1. _____
2. _____
3. _____

F. Describe the procedures, test records, or reports that were used as a basis for making this referral: Be specific and include cumulative record data (i.e. **please attach documentation of:** specific math scores, writing scores, work portfolio, district assessments, Title I screening,

etc.)

_____

_____

_____

_____

Describe any other factors which are relevant to this referral (i.e. moved several times, environmental factors, etc):

_____

_____

_____

Date and method the Parent(s)/Guardian(s) were made aware that you were making this referral and what specific problem(s), if any, have you discussed with the parent(s)?

_____

_____

_____

_____ _____

Signature (person making referral) *Date of Referral*

_____ _____

Signature of Building Principal *Date Signed by Principal*

_____ _____

Signature (person receiving referral) *Date received and accepted by Special Services*

c: Cumulative File
School Nurse
Director of Special Services