

PR-04 REFERRAL FOR EVALUATION

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CHILD'S INFORMATION

NAME: _____ ID NUMBER: _____
STREET: _____ GENDER: _____ GRADE: _____
CITY: _____ STATE: _____ ZIP: _____
DATE OF BIRTH: _____

BUILDING OF CURRENT ATTENDANCE: _____
TEACHER(S): _____
STUDENT'S NATIVE LANGUAGE (if not English): _____
PARENT'S NATIVE LANGUAGE (if not English): _____

PARENTS' / GUARDIAN INFORMATION

NAME: _____
STREET: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____

Reason for Referral:

EDUCATIONAL HISTORY

Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development:

Provide data from previous interventions, including Interventions required by rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

Number of school districts attended: _____

Years at present school building: _____

List schools/early childhood programs and dates:

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ATTENDANCE:

Regular Irregular

Is this student age-appropriate for grade level? Yes No

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with Vision Hearing
Does the student Wear Glasses Use hearing aid(s)
Does the student take medication Yes No

Does the student have any health/developmental/physical problems of which you are aware? Yes No

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school

For Preschool Children Only *(please check the area(s) of concern):*

- | | | | |
|--|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Dressing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Receptive Communication | <input type="checkbox"/> Expressive Communication | <input type="checkbox"/> Hearing | <input type="checkbox"/> Gross Motor |
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> Fine Motor | <input type="checkbox"/> Play | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Social/Emotional Behavior | | |
| <input type="checkbox"/> Other | | | |

Describe any other pertinent information not previously described:

SIGNATURES

_____ Signature of Person Initiating the Referral	_____ Signature of Person Receiving the Referral
_____ Position or Relationship to Student	_____ Title
_____ Date	_____ Date Received
	_____ Date District Suspects a Disability