Referral for Evaluation for Special Education Services Preschool

Student _____ DOB _____ Gender ____ Date _____

Street _____ Phone _____

Parent(s) _____ Ethnicity _____

Primary Language of Student _____ Primary Home Language _____

Area(s) of Concern (check all that apply):

Sensory/Motor
- ☐ Hearing
- ☐ Vision
- ☐ Motor
- ☐ Fine Motor
- ☐ Gross Motor

Social/Emotional
- ☐ Task Completion
- ☐ Following Direction
- ☐ Withdrawn
- ☐ Acting Out
- ☐ Peer Relationships

Communication
- ☐ Articulation
- ☐ Language
- ☐ Fluency/Stuttering
- ☐ Voice
- ☐ Listening/Understanding Skills

Self/Help/Adaptive
- ☐ Toileting
- ☐ Eating
- ☐ Dressing

Cognitive
- ☐ Attention and Memory
- ☐ Academic Skills

Comments: _____

Other Information

Has this student ever received other preschool services? ☐ Yes ☐ No If yes, where _____

Date of vision screening _____ ☐ Pass ☐ Fail Action _____

Date of hearing screening _____ ☐ Pass ☐ Fail Action _____

Health: ☐ Problem ☐ No Problem Comments: _____

Has this student been given any medical diagnosis?

If yes, what? where?

Is this student currently receiving any type of therapy?

If yes, what? _____

Day care name Address Phone _____

Does your child participate in other educational opportunities? If so, what and for how long?

_____

Person Making Referral _____ Date _____

Relationship to the Student ☐ Parent ☐ Teacher ☐ Other _____

If other than parent, is parent aware of referral? ☐ Yes ☐ No

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Action Taken:

☐ Screening recommended.
Send Consent for Evaluation and Procedural Safeguards

☐ No evaluation recommended at this time.
Provide notification and Procedural Safeguards

_____ _____

LEA or Designee Signature Signature Date