STUDENT REFERRAL FOR SPECIAL EDUCATION

DEPARTMENT OF SPECIAL EDUCATION/SEVIER COUNTY SCHOOLS

Indirect Observation

Date of Referral _____

Student _____ Birthdate _____ S.S. # _____
Last First Middle

School _____ Homeroom Teacher _____ Grade _____

Phone #:

Parent(s) _____ Home: _____ Work _____

Address _____
Street City Zip

Referring Person's Signature _____(Parent, LEA Personnel, or other)

Describe Specific Academic Strengths/Weaknesses: _____

_____

_____

Describe Specific Behavioral Strengths/Weaknesses: _____

_____

_____

INTERVENTIONS TRIED PRIOR TO REFERRAL:

_____

_____

_____

_____

_____

REASONS FOR REFERRAL: (List specific concerns.) _____

_____

_____

_____

_____

RECORDS REVIEW:

Vision Screening: Date _____Results: ___ Hearing Screening: Date _____Results___

Other Relevant Health Information: _____

_____

_____

Preschool Experience: Yes ___ No ___ N/A ___ (If yes, attach relevant documents such as assessment results and/or IFSP)

Days absent last year: ____ Days Absent Current Year ____ Grades repeated: _____

Currently receiving (mark all that apply):

Title l ___ Speech/Language ____ OT/PT ____ Individual Counseling ____ Other

_____

The following records are attached (*required for all referrals; +as applicable):

*Cumulative Records ___ *Discipline Records ___ *Classroom Observation(s) __

+TCAP (Terra Nova) Scores ___ +Competency Scores ___ +Writing Assessment ___

Disposition:

Notice of referral sent to assessment specialist(s) and SPED office _____(date)

Specify: __Psychologist __Sp/Lang __Vision __Hearing __OT/PT Other _____

If applicable: Complete packet sent to psychologist _____(date) Rev. 8/98