CONFIDENTIAL - PARENT REFERRAL FOR EVALUATION FOR ALL SERVICES

IDENTIFYING INFORMATION:

Student Name: _____ Date of Birth: _____ Age: _____
Street Address: _____
City, State Zip: _____
Parent/Guardian: _____ Telephone: _____
Building: _____ Grade: _____ Teacher:_____

What concerns are you having regarding your child? _____
_____
_____

CONCERNS: Please check areas of difficulty.

_____ Fine Motor _____ Gross Motor _____Sensory Issues _____ Behavioral
_____ Articulation _____ Academic _____ Emotional _____ Physical/Health
_____ Language _____ Other:_____

Why do you feel an evaluation would be beneficial to your child's success in the classroom?
_____
_____
_____

PREVIOUS INTERVENTIONS: As per regulation, this referral will not be processed without a complete explanation of the following questions.

1. Have you been to a child study team meeting? (ex. Intervention Team Meeting, CIM…) Y N
   If yes, date of Intervention Team Meeting:_____
   _____ check here if you would like to have a child study team meeting scheduled
2. Please list any previous/current services that your child has received.
   _____
   _____
   _____
   _____
3. Does your child have a Behavior Plan? _____ If yes, please describe.
   _____
   _____
   _____
4. Please complete the enclosed social history form and attach any additional evaluations and reports that you have for your child.
5. What is the best phone number and time to reach you in order to discuss this referral?
   Phone number: _____ Time: _____
   Email: _____ Permission to use text: Y N

Office Use Only:

TYPE OF REFERRAL:

_____ For Information Only (Individual Diagnostic Evaluation)
_____ Suspected Disability (Mandatory review by Committee on Special Education)

EVALUATIONS REQUESTED:

_____

Consent mailed to parent: _____

Definitions: (as identified by the Office of Vocational and Educational Services for Individuals with Disabilities. www.vesid.nysed.gov)

Delay in Cognitive Development:
A child with a cognitive delay or disability demonstrates deficits in intellectual abilities beyond normal variations for age and cultural background. This might include difficulties in:

- the ability to acquire information,
- problem solving,
- reasoning skills,
- the ability to generalize information,
- rate of learning,
- processing difficulties,
- memory delays,
- attention, and
- organizational skills.

Delay in Social-Emotional Development:
A child with a delay or disability in social-emotional development demonstrates deviations in affect or relational skills beyond normal variation for age and cultural background. These problems are exhibited over time, in various circumstances, and adversely affect the child's development of age-appropriate skills.

Delay in Motor Development:
A child with a delay or disability in motor development demonstrates a deficit beyond normal variability for age and experience in either coordination, movement patterns, quality, or range of motion or strength and endurance of gross (large muscle), fine (small muscle) or perceptual motor (integration of sensory and motor) abilities that adversely affects the child's ability to learn or acquire skills relative to one or more of the following:

- maintaining or controlling posture
- functional mobility (for example, walking or running),
- sensory awareness of the body or movement,
- sensory-integration,
- reach and/or grasp of objects,
- tool use,
- perceptual motor abilities (for example, eye-hand coordination for tracing), and
- sequencing motor components to achieve a functional goal.

Delay in Language and Communication:
A child with a delay or disability in language and communication demonstrates deficits beyond normal variation for age and cultural background that adversely affect the ability to learn or acquire skills in the primary language in one or more of the following areas:

- receptive language,
- expressive language,
- articulation/phonology,
- pragmatics
- fluency,
- oral-motor skills, or
- voice (such as sound quality, breath support).

PLEASE FILL IN, SIGN AND RETURN IN ENCLOSED SELF-ADDRESSED, STAMPED ENVELOPE

SPENCER-VAN ETTEN CENTRAL SCHOOL DISTRICT

SOCIAL HISTORY FORM

Student: _____ Today's Date: _____
Address: _____ Date of Birth: _____ Age: _____
_____ Grade: _____Home Telephone: _____

FAMILY HISTORY:

Mother: _____ Age: ____
Occupation: _____
Work Telephone: _____

Father: _____ Age: ____
Occupation: _____
Work Telephone: _____

Marital Status of parents: _____

Custody Arrangements: _____
_____
_____

BROTHERS/SISTERS:

Name: _____ Age: ____ Grade: _____
Name: _____ Age: ____ Grade: _____
Name: _____ Age: ____ Grade: _____
Name: _____ Age: ____ Grade: _____
Name: _____ Age: ____ Grade: _____
Name: _____ Age: ____ Grade: _____
Name: _____ Age: ____ Grade: _____

Others Living in Household:
_____
_____
_____
_____

MEDICAL/HEALTH INFORMATION:

1. Please comment about pregnancy, labor and delivery (e.g., normal, premature birth, cesarean birth, hard labor, some oxygen loss at birth, blue baby, etc.)
   _____
   _____
2. What was the birth weight? _____
3. Please list any significant illnesses or hospitalizations for the child since birth (e.g. ear infections, head injuries, operations, broken limbs, etc.)
   _____
   _____
   _____
4. Please list any significant developmental disability such as problem with learning to talk, walk or toilet training:
   _____
   _____
   _____
5. When was last physical examination? (Exact date please) _____ (computer only accepts exact date) Name of Family Physician: _____
6. Were there any recommendations from the physician as a result of last physical exam? If yes, please list.
   _____
7. Does the student have any other health problems that require medical attention (e.g., visual, hearing, etc.)
   Yes/No: _____ If yes, please list_____
   Medications/Reason: _____
   _____

(OVER)

SOCIAL HISTORY FORM (cont'd)

ABOUT THE STUDENT:

1. How does this student get along with other family members?
   _____
   _____

2. Please comment on some of your child's strengths.
   _____
   _____

3. Please comment on some of your child's weaknesses.
   _____
   _____

4. Please list any responsibilities/chores that the student has (e.g., clean his/her room, help with housework, feed pets, etc.).
   _____
   _____

5. How do you feel the child does in completing his/her chores? (e.g., needs reminders, does them without having to be told twice, usually doesn't do them, argues about doing them.)
   _____
   _____

6. What kind of discipline do you use with your son/daughter? (e.g., spanking, talking it out, sent to room, take privileges away)
   _____
   _____

7. Please identify any recent changes in your household that may be impacting your child's success (ex. Illness, death, moving, divorce, accidents, etc…).
   _____
   _____

EDUCATIONAL HISTORY:

1. Age student started school: _____

2. Has the student ever repeated a grade(s)? Yes _____ No _____
   If yes, what grade(s)? _____

3. Please list all school districts previously attended by this student: _____
   _____
   _____

4. Has the student ever participated in any of the following programs in school? (Check all that apply)
   Speech Therapy _____ Special Education _____ Resource Room _____
   Counseling at school _____ Private counseling _____ Occupational Therapy _____
   Remedial Reading/Math Support _____

_____ _____
Signature of person completing this form Relationship to student

_____
Signature of School Psychologist

HEALTH OFFICE REPORT

(School Nurse to fill in all information)

STUDENT NAME: _____ DATE OF BIRTH: _____

List siblings not in SchoolTool. _____ DOB /AGE_____

_____ DOB/AGE_____

HEALTH RECORD:

DATE OF LAST PHYSICAL EXAM: _____ PHYSICIAN: _____
STATUS/RECOMMENDATIONS/DIAGNOSIS:
_____
_____
_____

LIST CURRENT
MEDICATIONS:_____
_____

LAST AUDIOMETER TESTING: DATE: _____ RESULTS: _____
LAST VISUAL EXAMINATION: DATE: _____ RESULTS: _____

KNOWLEDGE OF PREVIOUS REFERRAL, PSYCHOLOGICAL OR PSYCHIATRIC SERVICES, ETC:
_____
_____
_____
_____

ADDITIONAL COMMENTS:
_____
_____
_____
_____
_____
_____