Referral to Early Childhood Special Education

Student Name: _____ **Birthday:** _____ **Age:** _____

Referring Teacher: _____ **Class day/time:** _____

Is parent aware of this referral? NO YES **Date of last Parent contact:**_____

Comments: _____

Has this child been through EC Screening? NO YES **DATE:** _____ **Where:**_____

Results: **DIAL 4** PASS/FAIL **ASQ-SE** PASS/FAIL

Screening comments:

_____

GENERAL INFORMATION	
Medical diagnosis? *Current medications?* *Previous evaluations/ services?* *Other agencies involved with family?* *Vision/hearing concerns?*	

REASON FOR REFERRAL (ALSO COMPLETE CHECKLIST)

INTERVENTIONS TRIED – LENGTH OF TIME TRIED? RESULTS?

STUDENT'S STRENGTHS

FAMILY INFORMATION:

Mother's Name: _____ **Email:** _____

Father's Name: _____ **Phone:** _____

Child resides with: BOTH Mom Dad Other **Phone 2:** _____

Address: _____

Referral received by: _____ Date referral received: _____

Date referral reviewed by team: _____

- □ Evaluate Evaluator/Teacher assigned: _____
- □ No evaluation at this time Follow up activities: