|  |  |
| --- | --- |
| **Date:** |  |

NOTE: GIVE PARENT COPY OF PRESCHLREFERRAL & CONSENT

NORTHEAST INDIANA SPECIAL EDUCATION COOPERATIVE

1607 E. Dowling Street

Kendallville, IN 46755

(260) 347-5236 1-800-589-5236 FAX (260) 347-1657

 *Preschool Referral for Multidisciplinary Educational Evaluation*

**Student Information:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Student:**  |  | **Date of Birth:**  |  | **Sex:** | **M** |  | **F** |  |
| **Address:** |  | **County of Residence:** |  |
| **Phone:** |  | **Home:** |  |  | **Cell:** |  |  | **Work:**  |  | (Indicate order of preference) |
| **Corporation:** |  | **Home School:** |  | **STN:** |  |
| **Referred By:** |  | **e-mail Address:** |  |

**Racial Background:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | American Indian or Alaskan Native |   | Hispanic/Latino, any race |  | White |
|   | Asian |  | Multi-Racial (not Hispanic) |  |
|   | Black/African American  |  | Native Hawaiian/Pacific Islander |

**Legal Custody:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Natural Parents  |  | Maternal Parent  |  | Paternal Parent  |  | Legal Guardian |  |  Other Relative  |  | Friend  |
|   | Education Surrogate Parent  |  | Other |  |

**Primary Language:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   | English  |  | Spanish |  | Dutch (Amish)  |  | Mandarin |  | German |  | Vietnamese |  | Korean |  | Japanese |
|  | Arabic |  | Russian |  | Serbian |  | Other (list) |  |

**Parent/Guardian Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Father’s Name**:  |  | Work Phone #: |  | Cell Phone #: |  |
| **Mother's Name**:  |  | Work Phone #: |  | Cell Phone #: |  |
| **Guardian's Name**:  |  | Work Phone #:  |  | Cell Phone #:  |  |

**Reason for this referral (check only suspected disability areas):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Developmental Delay |  | Speech or Language Impairment\*  |  | Intellectual Disability  |  | Multiple Disabilities  |
|  | Autism Spectrum Disorder |  | Deaf or Hard of Hearing |  | Blind or Low Vision |  | Orthopedic Impairment  |
|  | Transition from First Steps |  | Move-In |  | Other:  |  |

**Specific questions to be answered by this evaluation:**

**Developmental:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Gross or fine motor development |  | Screening  |  | Gross |  | Fine |  | Physical Therapy Evaluation |  | Occupational Therapy evaluation |
|  | Cognitive development |  | Receptive language development |  | Expressive language development |  | Social development |
|  | Emotional development |  | Self-help or other adaptive development |
| Comments:  |

**\*Speech and Language Referrals**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Speech problems |  | Language problems |  | Speech and language problems |
| Comments:  |

**Other**:

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Student Name:** |  | **Date:** |  |
| Has the child attended preschool? |  | Yes |  | No | If so, how many hours per week? |  |
| Past Evaluation? |  | Yes |  | No  |  | Copy Attached? |  | Yes |  | No |
| First Steps Services? |  | Yes, currently  |  | Yes, in the past |  | No | If yes, when/dismissal date |  |
| Past Special Education Services? |  | Yes |  | No | When: |  | Where? |  |
| Prosthetic devices prescribed? |  | Yes |  | No | What type (Glasses, Hearing Aid, etc)? |  |
| Used regularly?  |  | Yes |  | No |  |
| Language/Speech Impairment (LSI) remediation? |  | Yes |  | No | When: |  | Where: |  |
| Describe the child’s strengths: |
|  |
| Describe the concerns of the parent for enhancing the education of the student:  |
|  |
| Based on evaluation data, provide a statement of the student's present levels of academic achievement and functional performance, including how the student's disability/suspected disability affects the student's involvement and participation in appropriate activities. |
|  |
| Describe the evaluation procedure, assessment, record, report, or other relevant factors used as a basis for proposing to conduct the evaluation: |
|  |
| The decision to conduct this evaluation was based on: |
|  |
| Other factors relevant to this referral: |
|  |

**Must Be Completed By Designated Official**

|  |
| --- |
| **Initial in box below** |
| 1. Current Vision & hearing screening (Attached)  |  |
| 2. Family background/social history form completed (Attached) |  |
| 3. Documentation of Behavioral Problems, Interventions, and Functional Behavioral Assessment  for ED Referral (Attached)  |  |
| 4. Relevant medical data/reports  |  |
| 5. Referral, 2 pages completed.  |  |
| 6. Other pertinent documentation to reason for referral |  |
| 7. Date Request for Evaluation Initiated – verbal or written  |  | Parent |  | 1st Steps |  | School |  |  |
| 8. Date Written Notice of Intent to Evaluate provided to parent |  |  |
| 9. Date Parent Consent received  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Teacher Signature:** |  | **Date:** |  |
|   |
| **Intake Person/ Principal Signature:** |  | **Date:** |  |