Referral Form

Date of Referral: ______________________________County: ____

Name of Child: _______________________________SS#: _________________PA Secure ID#: ______________________

Address of Child: ____

Date of Birth: ________________________________Current Age: ________________Current Grade: _______________

Parents/Caregivers: ____

Home Phone #: _______________________________Home Address: ____

Can we contact the family? ❑ YES ❑ NO

Is the IEP being requested to be re-opened? ❑ YES ❑ NO

Is a functional assessment/visit to the child's placement being requested? ❑ YES ❑ NO

Primary Diagnosis:

____

Person making referral: ____

Phone # of person making referral: ____

Address of person making referral: ____

Is the person making the referral the main contact for this child? ❑ YES ❑ NO

If NO, then please list the name of the contact person with their phone and address:

____

Reason for referral (Please describe any eating, toileting, diet, behavior, etc. concerns.)

____

Does the child currently have a personal aide? ❑ YES ❑ NO

Does the child have a TSS that attends school with them? ❑ YES ❑ NO

If there is an aide or TSS, how many hours is this person with the child: _______________________________________

Does the child currently receive physical therapy services? ❑ YES ❑ NO How many hours? __________________

Does the child currently receive occupational therapy services? ❑ YES ❑ NO How many hours? ______________

Does the child currently receive speech and language therapy services? ❑ YES ❑ NO How many hours? ________

Home School District: ____LEA ID #: ____________________________

Home District contact & phone #: ____

Child's current placement: ____

Date of last IEP: ____

Other information: ____

Sign: ____ Date:_________________________________