

MILWAUKEE PUBLIC SCHOOLS
 DEPARTMENT OF SPECIAL SERVICES
REFERRAL FORM:
SPECIAL EDUCATION AND RELATED SERVICES

Initial Reevaluation

Name of Student (Last, First, Middle Initial):		Date of Birth:	Grade:	Referral Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnic Code:	ID#:		
Name of Parent or Legal Guardian:			Address (Street, City, State, Zip):						
Student Lives With (Name and Relationship):			Address (Street, City, State, Zip):						
Attending School:				Evaluating School:					
Method of notifying parent of intent to refer:				<input type="checkbox"/> Conference		<input type="checkbox"/> Phone Call		<input type="checkbox"/> Written	
Parent Telephone (Home): _____					Date parent notified of intent to refer:				
Parent Telephone (Work): _____									
Parent Telephone (Alt.): _____									
Parent's or adult student's native language or other primary mode of communication:					Is an interpreter needed for parent? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Student's native language or other primary mode of communication:				Person Making Referral (Name and Title):					

State reason you believe this child has a disability (impairment and a need for special education) – such as academic and nonacademic performance and medical information; any special programs, services, interventions used to address this student's needs and the results of those interventions, etc.

REASONS FOR REFERRAL:

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| <input type="checkbox"/> Academic/pre-academic delays | <input type="checkbox"/> Visual Problem | <input type="checkbox"/> Physical/Medical Problems |
| <input type="checkbox"/> Problems with Learning | <input type="checkbox"/> Communication Problems | <input type="checkbox"/> Sensory/Perceptual skills |
| <input type="checkbox"/> Behavioral - Emotional Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Delayed self help skills |
| | | <input type="checkbox"/> Other: _____ |

REFERRAL CONCERNS:

CURRENT INTERVENTIONS/RESULTS OF INTERVENTIONS:

STRENGTHS:

If a child is transitioning from a Birth to 3 Early Intervention Program, and the district was invited by the designated lead agency to participate in the transition planning meeting, document the date of the meeting and who attended for the LEA or explain why the LEA did not attend.

NA LEA attended Date: _____ Name: _____ LEA did not attend

School district representative receiving referral:		Date (mo/dy/yr) of receipt of referral by school district/LEA: <i>(Note: The date the district receives the referral begins the 15 business day timeline in which to complete the review of existing information and notify the parents of whether additional assessments are needed.)</i>
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