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: _____