Kern County SELPA

School District

Referral for Evaluation

REQUEST for: (check as needed)

- ☐ Audiological Evaluation/Consultation
- ☐ Adaptive Physical Education Evaluation/Consultation
- ☐ Vision Specialist Evaluation/Consultation
- ☐ Augmentative/Assistive Technology Evaluation/Consultation
- ☐ Orientation and Mobility Evaluation/Consultation
- ☐ Occupational Therapy Evaluation/Consultation
- ☐ Other ______________________________

When requesting an evaluation and/or consultation, please consider the following

- This form must be completed with copies of all reports included.
- For occupational therapy: If the student is a client of the California Children Service, please refer the student to that agency for occupational therapy consultation/services.
- Current is considered to be within the last year when referring to evaluations and reports.

After a brief consultation, determination for a formal assessment will be made. DO NOT complete or obtain parent permission for assessment at the time this form is submitted. The date on which all the needed information is received will determine the referral date.

Date ______________

Student: ______________________________ Gender __________

Birthdate __________ Age ___ Grade ___ Primary Service ______________

District ______________________ School ______________________

Referred by ______________________ Phone ______________

Parent(s) Name(s) ______________________________

Phone (h): __________ Phone (w): __________ Phone (msg): __________

Mailing Address ______________________________

Contact Person/Title ______________________ ______________

Phone ______________________ FAX ______________________

Mail this form with accompanying reports to:

____

____

____

cc: KCSOS, District, Specialist

Rev. 2/04 Referral for Evaluation.p65

(Page 2 must be completed)

REQUEST FOR CONSULTATION / EVALUATION
the following areas must be completed prior to any referral consideration.

1. List the specific concerns that are impeding the student's learning:

a. ______________________________
b. ______________________________
c. ______________________________
d. ______________________________

2. List interventions that have been attempted in the classroom to resolve the above concerns:

☐ Student received pre-referral early intervening services in the past two years.

a. ______________________________ Early Intervention
b. ______________________________ Early Intervention
c. ______________________________ Early Intervention
d. ______________________________ Early Intervention

3. List any special education services presently provided or being considered:

	Services	Teacher	Being Considered/Avoided
a.			
b.			
c.			
d.			

4. List the student's other teachers and programs or classes:

	Teacher	Program/Class
a.		
b.		
c.		
d.		

5. If transfer student, attach copy of last district's assessment / IEP

SERVICES	YES	NO
a. Is the student no receiving or has the student received occupational therapy (OT) or physical therapy (PT)?	☐	☐
b. Is the student receiving any private therapy?	☐	☐
c. Is there a current vision screening report?	☐	☐
d. Is there a current hearing screening report?	☐	☐
e. Is the student a client of Kern Regional Center?	☐	☐
f. Is the student a client of California Children Services?	☐	☐
g. Is there a current psycho-educational report?	☐	☐
h. Date of last IEP? ______________	☐	☐
i. Are there any other agencies involved?	☐	☐

Additional Comment(s):

____
____
____
____

* IF YES, A COPY OF THE REPORT **MUST** BE ATTACHED TO THIS REQUEST.