

Referral for Evaluation

To: _____

Parent/Guardian

Initial Referral Date: _____

A request has been submitted for a special educational evaluation of your child. The primary reason for this request is:

- | | |
|------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Academic Delays | <input type="checkbox"/> Emotional/Behavioral/Social |
| <input type="checkbox"/> Speech and Language | <input type="checkbox"/> Audiological/Vision |
| <input type="checkbox"/> Motor Areas | <input type="checkbox"/> Health |
| <input type="checkbox"/> Delays in expected progress | <input type="checkbox"/> Previous Placement/Transfer |
| <input type="checkbox"/> Parent Request | <input type="checkbox"/> Other: _____ |

Your child, _____ has been referred for assessment. Not all students who are having difficulties in school will need special education.

In order to determine the needs for special education services, it is necessary to conduct an assessment. Within fifteen (15) days of the referral date, an assessment plan will be developed that outlines the areas in which your son/daughter needs to be evaluated.

An Individualized Education Program (IEP) Team meeting will be scheduled to review the results of the assessment. The results of the assessment will help us make recommendations for programs or services to be provided at no cost to you in order to more adequately meet your son's/daughter's educational needs.

No special education service(s) will occur without your written permission.

The individuals supervising the assessment process is:

Name: _____

Title: _____

Phone: _____