

REFERRAL FOR EVALUATION



Eastern Illinois Area of Special Education
5837 Park Drive, Suite 1
Charleston, IL 61920
Phone: 217/348-7700
FAX: 217/348-7704

(for office use only)

Date Received: _____

Referral Number: _____

Assigned To: _____

Referred by: teacher parent other (specify): _____

DESCRIPTIVE INFORMATION:

SS#: _____

Student Name: Last: _____ First: _____ Middle: _____

DOB: _____ Gender: F M Teacher: _____ Age: _____ Yr. _____ Mo.

Resident District: _____ Grade: _____

Current Attendance Center: _____

Name: _____ **Address:** _____ **Phone:** _____

Surrogate Parent Ed: _____

Parent: _____

Parent: _____

Father's Employer: _____

Mother's Employer: _____

Primary Language: _____ Mode of Communication: _____

Level of English Proficiency: _____

Ethnic Code: _____

Cultural Background: _____

Date of most recent vision test: _____ Pass Fail

Date of most recent hearing test: _____ Pass Fail

Previous Evaluation(s): _____

Audiological: _____ Psychological: _____ Speech/Language: _____

Referral Type: Initial or Reevaluation: Triennial Other: _____

Reasons for referral (indicate "P" for primary and "S" for secondary):

____ Preacademic ____ Academic ____ Behavior/Emotional ____ Sensory/Motor ____ Speech/Language

____ Hearing ____ Vision ____ Other (specify): _____

Describe communication between home and school:

Date this referral was discussed with parent: _____ By whom: _____

Person Completing Form: _____

Signature of Person: _____

Position: _____

Signature of Principal: _____