

## Request for Regional Services and/or Evaluation for Eligibility

<input type="checkbox"/> <b>New Referral</b>		<input type="checkbox"/> <b>Move-in-Referral</b>		<b>SSID #</b>		<b>District Student ID:</b>	
<b>Student Name:</b>						<b>Date of Birth:</b>	
<b>Attending School:</b>				<b>Attending District:</b>			
<b>Resident School:</b>				<b>Resident District:</b>			
<b>Grade:</b>		<b>Age:</b>		<b>Gender:</b>		<b>Primary Language:</b>	
<b>Parent/Guardian:</b>							
<b>Address:</b>							
<b>Phone:</b>		<b>Cell Phone:</b>		<b>Email:</b>			
<b>Primary Eligibility:</b>		<b>Secondary Code 1:</b>		<b>Secondary Code 2:</b>		<b>Secondary Code 3:</b>	
<b>Case Manager:</b>				<b>Email:</b>		<b>Phone:</b>	
<b>Date Parent Consent Signed:</b>				<b>Eligibility meeting to be held on or prior to:</b>			
<b>Current IEP:</b> <input type="checkbox"/> NO <input type="checkbox"/> Yes - Date:				<b>Current IEP Annual Review Due Date:</b>			

<b>Request for WESD Evaluations:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Audiological Evaluation</li> <li><input type="checkbox"/> Augmentative Communication/Assistive Technology</li> <li><input type="checkbox"/> Autism Spectrum Disorder</li> <li>Communication Evaluation to be completed by: _____</li> <li><input type="checkbox"/> Functional Vision Evaluation (please send eye examination report with referral)</li> <li><input type="checkbox"/> Occupational Therapy</li> <li><input type="checkbox"/> Physical Therapy</li> <li>For OT or PT evaluation, please list current diagnosis, if applicable: _____</li> <li><input type="checkbox"/> Traumatic Brain Injury</li> </ul>	<b>Request for WESD Regional Services:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Augmentative Communication/Assistive Technology</li> <li><input type="checkbox"/> Autism Spectrum Disorder Services</li> <li><input type="checkbox"/> Deaf/Hard of Hearing Services</li> <li><input type="checkbox"/> OT- Motor Services</li> <li><input type="checkbox"/> PT- Motor Services</li> <li><input type="checkbox"/> Traumatic Brain Injury</li> <li><input type="checkbox"/> Vision Services</li> <li><input type="checkbox"/> Other- provide detailed explanation</li> </ul>
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**Please submit referral and any accompanying documentation to:  
Special Education Director or delegate**

<b>Referral Authorized By:</b>	<b>Phone:</b>	<b>Date:</b>
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**Reason for Referral/Additional Information:**

The Case Manager is responsible for providing student file information and Consent to Evaluate to the Regional Specialist.

<b>Office use only</b>			
WESD Evaluator Assigned:	WESD Evaluator Assigned:	WESD Evaluator Assigned:	WESD Evaluator Assigned:
Assigned By: Date:	Assigned By: Date:	Assigned By: Date:	Assigned By: Date:

## Supporting Documents

### Autism Spectrum Disorder Services

The following is to be completed by the district and must accompany a Referral for eligibility determination:

- ☐ Copy of the signed Consent for Evaluation for:
  - Behavioral observations
  - File review
  - ASD Rating Scale
  - Developmental Profile
  - Team/Parent Interviews

☐ Copies of any prior assessments that led to this referral such as: communication Disorder evaluation, psychological report, autism screening checklist, IFSP/IEP, observation notes, etc.

**For students who have moved into the district with a current ASD eligibility (82), the following should be attached to the referral:**

- ☐ Eligibility Statement
- ☐ Signed Medical Statement
- ☐ Current IFSP/IEP
- ☐ Current communication evaluation report
- ☐ Psycho educational report, if available
- ☐ Developmental Profile
- ☐ Medical Statement or Health Assessment
- ☐ Documentation of behavioral observations
- ☐ Autism Behavior Checklist

### Deaf/Hard of Hearing Services

The following is to be completed by the district and must accompany a Referral for eligibility determination:

- ☐ Copy of the signed Consent for Evaluation for:
  - Classroom observation
  - File review
  - Observation/Questionnaire forms
- ☐ Two failed hearing screenings OR a current audiological assessment OR wearing hearing aids, i.e. move-in from another district, etc.

**The following is to be completed prior to the initial eligibility meeting (this can be obtained by the district or our office):**

- ☐ Physician's Statement

**For students who have moved into the district with a current HI eligibility (20), the following should be attached to the referral:**

- ☐ Eligibility Statement
- ☐ Signed Medical Statement
- ☐ Current IFSP/IEP
- ☐ Current Audiological Evaluation Report

### Vision Services

The following is to be completed by the district and must accompany a Referral for eligibility determination:

- ☐ Copy of the signed Consent for Evaluation for:
  - Classroom observation
  - Functional Vision Assessment
- ☐ Copy of an Eye Report from an ophthalmologist or optometrist

**For students who have moved into the district with a current VI eligibility (40), the following should be attached to the referral:**

- ☐ Eligibility Statement
- ☐ Signed Eye Report from an ophthalmologist or optometrist
- ☐ Signed Functional Vision Report
- ☐ Current IFSP/IEP

### Orthopedic Services

The following is to be completed by the district and must accompany a Referral for eligibility determination:

- ☐ Copy of the signed Consent for Evaluation for:
  - Classroom observation
  - File review
  - EI/ECSE Age: PDMS-2; OREST
  - School Age: Functional Motor Assessment; OREST
  - Feeding Evaluation (if applicable)
  - Sensory Evaluation (if applicable)

**For students who have moved into the district with a current OI eligibility, the following should be attached to the referral:**

- ☐ copy of the signed Consent for Evaluation
- ☐ Signed Physician's Statement or medical report which includes diagnosis with physician's signature
- ☐ Current IFSP/IEP (services can be added when eligible)
- ☐ Statement of Eligibility-Orthopedic Impairment (70)