

# PR-04 REFERRAL FOR EVALUATION

DISTRICT: \_\_\_\_\_

## CHILD'S INFORMATION

NAME: \_\_\_\_\_ ID NUMBER: \_\_\_\_\_

STREET: \_\_\_\_\_ GENDER: \_\_\_\_\_ GRADE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: OH ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

NAME: \_\_\_\_\_

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: OH ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

NAME: \_\_\_\_\_

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: OH ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

## BUILDING OF CURRENT ATTENDANCE:

\_\_\_\_\_

## TEACHER(S):

\_\_\_\_\_

## STUDENT'S NATIVE LANGUAGE (If Not English):

\_\_\_\_\_

## PARENT'S NATIVE LANGUAGE (If Not English):

\_\_\_\_\_

## Reason for Referral:

\_\_\_\_\_

## EDUCATIONAL HISTORY

Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development:

\_\_\_\_\_

Provide data from previous interventions, including interventions required by Rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

\_\_\_\_\_

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

\_\_\_\_\_

Number of school districts attended: \_\_\_\_\_

Years at present school building: \_\_\_\_\_

List schools/early childhood programs and dates:

\_\_\_\_\_

## ATTENDANCE:

Regular  Irregular

Is this student age-appropriate for grade level?  Yes  No

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## BACKGROUND INFORMATION

### A. Health Data

- Do you suspect problems with  Vision  Hearing  
Does the student  Wear Glasses  Use Hearing Aid(s)  
Does the student take medication  Yes  No

If yes, specify type and purpose:

Does the student have any health/developmental/physical problems of which you are aware?  Yes  No

If yes, please explain:

### B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school:

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**For Preschool Children Only (please check the area(s) of concern):**

- |  |  |                                    |                                      |
|--|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Eating                  | <input type="checkbox"/> Dressing                  | <input type="checkbox"/> Toileting | <input type="checkbox"/> Attention   |
| <input type="checkbox"/> Receptive Communication | <input type="checkbox"/> Expressive Communication  | <input type="checkbox"/> Hearing   | <input type="checkbox"/> Gross Motor |
| <input type="checkbox"/> Cognitive               | <input type="checkbox"/> Fine Motor                | <input type="checkbox"/> Play      |                                      |
| <input type="checkbox"/> Vision                  | <input type="checkbox"/> Social/Emotional Behavior |                                    |                                      |
| <input type="checkbox"/> Other                   |  |                                    |                                      |

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Describe any other pertinent information not previously described:

## SIGNATURES

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Signature of Person Initiating the Referral

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Signature of Person Receiving the Referral

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Position or Relationship to Student

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Title

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Date

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Date Received

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Date District Suspects a Disability