

Gila Crossing Community School Staff Referral for a Special Education Evaluation
Please complete this form electronically and return it to Mr. Twitchell electronically

Name of Student	NASIS ID	DOB	Grade	Today's Date
Parents/Guardians	Phone number(s)		Email	
Oral expression and/or articulation skills (speech)				
Reading fluency skills				
Listening comprehension skills				
Math calculation skills				
Basic reading skills				
Math problem solving skills				
Emotional status (i.e., temperament)				
Level of activity in the classroom				
Level of attention in the classroom				
Level of effort/motivation in the classroom				
Peer relationships				
Staff relationships				
General health				
Vision and hearing status				
Gross and fine motor skills status				
Intervention, services or programs that have been implemented to help this specific student				
Effectiveness of the interventions, services or program implemented to help this specific student				
Communication (phone, email, letters, face-to-face meeting) with parent regarding these concerns				
Any other relevant information?				

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Please check any and all of the categories of disability you suspect may be impacting this student's ability to be involved in and progress in the general education curriculum:

- ☐ Autism ☐ Developmental Delay ☐ Emotional Disability ☐ Hearing Impairment
☐ Intellectual Disability ☐ Specific Learning Disability ☐ Speech Language Impairment
☐ Traumatic Brain Injury ☐ Other Health Impairment ☐ Visual Impairment

Name and job title of the GCCS staff making this referral
Date of this referral
What will be your availability (dates & times) to attend a multidisciplinary evaluation team regarding this referral?

For SPED Department Use Only

Signature and date of receipt of this referral