NOTE: If after 3 days you Do Not receive an email containing this referral, please contact

Butte County SELPA Phone: (530) 532-5621 Email: jdolan@bcoe.org

|  |  |  |
| --- | --- | --- |
| **Your Name**  | **Your Title**  | **Date Submitted**  |
| **Your Phone #** | **Your Email** | **LAST IEP DATE** |
| **Student’s Legal Name** | **DOB** | **Age** | **M** **[ ]  F** **[ ]**  |
|  |
| Interventions Implemented: [ ]  Yes [ ]  No |       |
| Student Study Team Meeting Held: [ ]  Yes [ ]  No | Date of Student Study Team Meeting:  |
| Consultation with Specialist : [ ]  Yes [ ]  No | Name: |
| **SERVICES CURRENTLY RECEIVING FOR SPECIAL EDUCATION**  |
|  **[ ]** Adapted Physical Education **[ ]** Occupational Therapy **[ ]** Orientation & Mobility [ ]  Deaf/Hard of Hearing **[ ]** Orthopedic Impairment **[ ]** Speech **[ ]** Vision Services |
| **REASON FOR REFERRAL**  |
| **PRIMARY and SECONDARY HANDICAPPING CONDITION**[ ]  Autism [ ]  Visual Impairment [ ]  Deafness[ ]  Emotional Disturbance [ ]  Established Medical Disability [ ]  Hard of Hearing[ ]  Intellectual Disability (Mental Retardation) [ ]  Multiple Disabilities [ ]  Orthopedic Impairment[ ]  Other Health Impairment [ ]  Specific Learning Disability [ ]  Traumatic Brain Injury[ ]  Speech or Language Impairment |
| **Principal Language of Home**  | **Student’s Primary Language**  |
| **Does the assessment plan and parent questionnaire need to be sent in Spanish?** **[ ] Yes** **[ ] No** |
| **PARENT/CARE PROVIDER INFORMATION** |
| **Parent/Educational Rep. Name** | **Relationship to Student**  |
| **Mailing Address**  | **City**  | **State** **CA** | **Zip**  | **Phone Number** |
| **Is Parent Aware of Request?** [ ]  **Yes** [ ]  **No** [ ]  **Unknown** |
| **CURRENT SCHOOL INFORMATION** |
|  **Student District of Residence**  | **Current School of Attendance**  |
| **Type of Class:** | **Grade:** | **Teacher Name:** |
| **FOR FOSTER CHILDREN ONLY** |
| **Natural Parent Name:** | **Placing Agency:** |
| **Educational Representative:** | **Appointment of Educational Representative Letter on File?** [ ]  **Y** [ ]  **N** [ ]  **Unknown** |
| **FOR EARLY START ONLY** |
| ***Physicians Involved With Child* :** |
| ***Agencies Involved With Child:*** |

**NOTE:** Please submit this Referral Form via email once it is completed to jdolan@bcoe.org, write whatever message you’d like in the body and send. Thank you.