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](mailto:jdolan@bcoe.org)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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](mailto:jdolan@bcoe.org), write whatever message you’d like in the body and send. Thank you.