|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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?** |
|  |

**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

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| --- |
| **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

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| --- |
| **Signature and date of receipt of this referral** |
|  |