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| --- | --- | --- | --- | --- | --- | --- |
| **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** | | | | | | |
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| **Listening comprehension skills** | | | | | | |
|  | | | | | | |
| **Math calculation skills** | | | | | | |
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| **Basic reading skills** | | | | | | |
|  | | | | | | |
| **Math Problem Solving Skills** | | | | | | |
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| **Emotional status (i.e., temperament)** | | | | | | |
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| **Level of activity in the classroom** | | | | | | |
|  | | | | | | |
| **Level of attention in the classroom** | | | | | | |
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| **Level of effort/motivation in the classroom** | | | | | | |
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| **Peer relationships** | | | | | | |
|  | | | | | | |
| **Staff relationships** | | | | | | |
|  | | | | | | |
| **General health** | | | | | | |
|  | | | | | | |
| **Vision and hearing status** | | | | | | |
|  | | | | | | |
| **Gross and fine motor skills status** | | | | | | |
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| **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

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| **Name and job title of the GCCS staff making this referral** |
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| **Date of this referral** |
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|  |
| **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** |
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