



4500 6<sup>th</sup> Avenue, Altoona, PA 16602  
P: 814-940-0223/Fax: 814-949-0984

### PRESCHOOL REQUEST FOR SERVICES/RELATED SERVICES FORM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ GENDER: \_\_\_\_\_

PHONE: \_\_\_\_\_

PARENT EMAIL: \_\_\_\_\_

ACCESS ELIGIBLE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

PA SECURE ID: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

SCHOOL DISTRICT OF RESIDENCE: \_\_\_\_\_

ANTICIPATED BUILDING OF ATTENDANCE: \_\_\_\_\_

DAYS OF ATTENDANCE: M ☐ T ☐ W ☐ Th ☐ F ☐

TIMES OF ATTENDANCE: \_\_\_\_\_

IU8 PRESCHOOL STAFF ASSIGNED TO STUDENT: \_\_\_\_\_

**\*FOR RE-EVALUATIONS ONLY:**

LEAD IU8 STAFF MAKING THE RE-EVAL REQUEST: \_\_\_\_\_

IU8 STAFF ASSIGNED TO THE RE-EVAL: \_\_\_\_\_

DIAGNOSIS/EXCEPTIONALITY: \_\_\_\_\_

\*REASON FOR REFERRAL: \_\_\_\_\_

TYPE OF SERVICES/EVALUATION REQUESTED:

\*If student is moving into IU8 programming with an existing IEP, please select 'services' as listed in the student's current IEP.

Speech: ☐ Evaluation ☐ Re-Evaluation ☐ Services ☐ Screening

Physical Therapy: ☐ Evaluation ☐ Re-Evaluation ☐ Services ☐ Screening

Occupational Therapy:

☐ Evaluation ☐ Re-Evaluation ☐ Services

☐ Initiate the OT Pre-Referral process (this will require teacher input)

Vision: ☐ Evaluation ☐ Re-Evaluation ☐ Services

Deaf/Hard of Hearing:

☐ Evaluation ☐ Re-Evaluation ☐ Services

Social Work: ☐ Evaluation ☐ Re-Evaluation ☐ Services

For Social Work Referrals, has the parent been contacted and this service discussed:

\*Please include a signed parent permission for an initial or re-evaluation for services, indicating the evaluation that is to be completed.

For PT/OT service requests, please provide the student's physician information so that a prescription for services can be obtained.

Student's Physician: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

SERVICE COORDINATOR: \_\_\_\_\_

Additional Comments/Information relevant to this referral: