

SPECIAL EDUCATION REFERRAL FORM

112 South Elliott Street
Wenatchee, WA 98801
(509) 663-7117

Name of Student _____ Grade _____
School _____ Teacher _____
Age _____ Birth Date _____ Sex: Male ___ Female ___
Sign or language interpreter needed? Yes ___ No ___ Home language _____
Parent/Guardian _____ Work Phone _____
Address _____ Home Phone _____
Surrogate Needed? Yes ___ No ___ Name _____
Parents contacted by _____ Referred by _____
Date parent notified of referral by Child Study Team _____

REASON FOR SPECIAL EDUCATION REFERRAL

Noticeable delays or problems in: (please circle)

- | | | |
|-----------------|--------------------|-----------------------------|
| 1. Cognitive | 6. Writing | 11. Behavior |
| 2. Health | 7. Personal/Social | 12. Listening Comprehension |
| 3. Hearing | 8. Reading | 13. Oral expression |
| 4. Math | 9. Speech/Language | 14. Other |
| 5. Motor skills | 10. Vision | |

SUMMARY OF EXISTING INFORMATION

Prior Screenings / Assessments:

Educational – Date _____	Result _____
Physical/Medical – Date _____	Result _____
Adjustment – Date _____	Result _____

Referrals to outside specialists:

History of outside evaluations:

Attendance (days absent this school year) _____ Retention _____

Number of years of formal schooling _____

PREVIOUS EDUCATIONAL INTERVENTIONS

Learning or Behavioral Concerns (be specific and attach work samples if necessary)	Interventions	Duration	Outcome

ENROLLMENT IN OTHER PROGRAMS: (prior referrals to building specialists)

	Intervention	Duration	Outcome
Bilingual			
Chapter 1			
Counseling			
Gifted			
Indian Education			
Learning Assistance Program (LAP)			
Remedial Reading			
Special Education			
Speech/Language			
Other (please describe)			

Screening information – Health Screening (Attach developmental history, if appropriate.)

Vision: Date _____ **Eye Glasses:** Yes ___ No ___

Both	Right	Left
WO 20/	WO 20/	WO 20/
W 20/	W20/	W20/

Hearing: Date _____ A/C _____ B/C _____

	500	1000	2000	4000
R				
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Specific Health Concerns:

Other Screening Results:

Focus of concern must be accompanied by complete Child Study documentation to Special Services.

Signature _____ Title _____

Principal's Signature _____ Date _____

Special Services Records Clerk _____ Date _____

Special Services District Representative _____ Title _____ Date _____

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 663-7117

EDUCATIONAL RATING SCALE

NAME: _____ **BD:** _____

(TO BE COMPLETED BY CLASSROOM TEACHER)

Fill in your estimate of the student's grade levels and complete rating scales.

READING:

Student is reading in what grade level text? _____

Reading comprehension at what grade level? _____

Does student primarily decode words or is he a sight reader? _____

SPELLING:

Spelling skills are at what grade level? _____

ARITHMETIC:

Computation skills are at what grade level? _____

Applied math skills are at what grade levels? _____

WRITING: (Rate the following writing skills - circle one)

Printing	Poor	Fair	Average	Good	Excellent
Cursive	Poor	Fair	Average	Good	Excellent

SPEECH AND LANGUAGE: (Rate the following writing skills - circle one)

Articulation	Poor	Fair	Average	Good	Excellent
Understanding of language	Poor	Fair	Average	Good	Excellent
Oral Expression	Poor	Fair	Average	Good	Excellent
Written Expression	Poor	Fair	Average	Good	Excellent

ADJUSTMENT: (Rate the following social & emotional skills - circle one)

Makes friends with peers	Poor	Fair	Average	Good	Excellent
Relates with adults	Poor	Fair	Average	Good	Excellent
Cooperative	Poor	Fair	Average	Good	Excellent
Follows school rules	Poor	Fair	Average	Good	Excellent
Self-confident	Poor	Fair	Average	Good	Excellent
Participates in group activities	Poor	Fair	Average	Good	Excellent
Emotional stability	Poor	Fair	Average	Good	Excellent

SELF-HELP: (Rate the following self-help skills - circle one)

Responsible	Poor	Fair	Average	Good	Excellent
Self-starter	Poor	Fair	Average	Good	Excellent
Works independently	Poor	Fair	Average	Good	Excellent

COMMENTS:

Teacher's Signature

Date

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LEARNING DISABILITY CHECKLIST

Child's Name: _____ Age: _____ Birthdate: _____

Grade: _____ School: _____ Teacher: _____ Date: _____
Yes No

Doesn't seem to listen to daily classroom instructions or directions. (Often asks to have them repeated whereas the rest of the class goes ahead.).....

Has difficulty correctly recalling oral directions when asked to repeat them

Unable to learn or pronounce the sounds of letters

Has trouble organizing written work, often seems confused

Avoids work requiring concentrated visual retention

Is slow to finish written work

Difficulty in copying, both at near and far points.....

Reverses and/or rotates letters, numbers or words when reading

Reverses and/or rotates letters, numbers or words when writing

Poor eye-hand coordination . . . (Difficulty writing, cutting, tracing)

Indications of directional confusion. (Confuses left-hand with right-hand side of paper. Eye movements indicate a right to left pattern of reading movement)

Loses place easily while reading aloud

Has difficulty sounding out or "unlocking" words

Seems very bright in many ways but still does poorly in school

Easily distracted from school work. (distracted by normal classroom noise).....

Overactive, can't sit still in class

Has difficulty expressing himself, thoughts seem confused

Classroom comments are often "off the track" or peculiar

Upset by changes in routine

Inclined to become confused in number processes. Gives illogical responses

Has difficulty spelling accurately words that can be read

Substitutes words while reading material aloud

Signature

Date