

<b>School District/Public Agency</b>	<b>Referral - Special Education</b> 34 C.F.R. §300.301(b)
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<b>Name of Student</b>		<b>WISER ID</b>	<b>DOB</b>	<b>Grade</b>	<b>Date</b>
<b>Name(s) of Parent or Guardian</b>			<b>Name(s) of Parent or Guardian</b>		
<b>Address (City, State &amp; Zip)</b>			<b>Address (City, State &amp; Zip)</b>		
<b>Contact Information</b>			<b>Contact Information</b>		
<b>H:</b>	<b>C:</b>	<b>H:</b>	<b>C:</b>		
<b>W:</b>	<b>Email:</b>	<b>W:</b>	<b>Email:</b>		

**Reason for Referral**

<b>State reason(s) you believe that the child has a disability and needs special education and related services. Explain in detail the child’s academic and nonacademic performance. Include any important medical, emotional or other health related information.</b>

**Interventions and Effects**

<b>Discuss and detail any interventions, services or other programs used to address the child’s needs. Include information about the duration of the interventions, services or programs that were attempted and the effects of the interventions on the child’s performance, to the extent known.</b>

<b>Name of Student</b>	<b>DOB</b>	<b>Grade</b>

### Vision and Hearing Screening

**Document the results of vision and hearing screening; any failed portion indicates a failed screening.**

**Vision Screening**

Date Performed: \_\_\_\_\_

Vision is:  CORRECTED (glasses/contacts)  UNCORRECTED

	BOTH	LEFT	RIGHT
Distance Acuity	20/	20/	20/
Near Acuity	20/	20/	20/
Tracking	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL		
Stereo Vision	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL		
Color Vision	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL		

Notes: \_\_\_\_\_

**Hearing Screening**

Date Performed: \_\_\_\_\_

**OTOSCOPY:**

PURE TONE RESULTS @ 20 dB	1.0 kHz	2.0 kHz	4.0 kHz
Right Ear	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
Left Ear	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL

**TYMPANOMETRY**

	PRESSURE	COMPLIANCE
Right Ear	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
Left Ear	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL

Notes: \_\_\_\_\_

### Parent Involvement

Indicate how the concerns have been addressed with parent(s).

Signature of Person Making the Referral: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

For Agency Use Only

<b>Name &amp; Title of Public Agency Representative Receiving Referral</b>	<b>Date of Receipt of Referral</b>	<b>Procedural Safeguards Provided to Parent for Initial Referral 34 C.F.R. §300.504(a)(1)</b>
		By: _____ Date: _____