

**REFERRAL APPLICATION – Part I**  
**COUNTY/DISTRICT/SCHOOL INFORMATION**

Diagnostic Center Use Only
Referral No: <input type="text"/>

REFERRING SCHOOL DISTRICT	DATE OF APPLICATION	REFERRAL INITIATED BY: <input type="checkbox"/> Parent <input type="checkbox"/> LEA
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STUDENT INFORMATION:			
STUDENT NAME (Last, First, MI)		PARENT OR GUARDIAN'S NAME	
ADDRESS		PARENT CONTACT PHONE NUMBERS MOTHER                      FATHER	
CITY/STATE/ZIP CODE		HOME: _____	
COUNTY		WORK: _____	
DATE OF BIRTH	ETHNICITY	CELL: _____	
GRADE	LANGUAGES SPOKEN IN THE HOME:		
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	STUDENT IS: <input type="checkbox"/> Fluent English Speaking (FES) <input type="checkbox"/> Limited English Proficient (LEP) <input type="checkbox"/> Non-English Speaking (NES) Primary Language _____		INTERPRETER NEEDED FOR PARENT: <input type="checkbox"/> YES <input type="checkbox"/> NO

FEDERAL HANDICAPPING CONDITIONS PLEASE ✓ APPROPRIATE BOX(ES)			Multi-handicap Subcategories (Use only if 110 checked)	
<input type="checkbox"/> 010 Mental Retardation (MR)	<input type="checkbox"/> 020 Hard of Hearing (HH)	<input type="checkbox"/> 010 MR	<input type="checkbox"/> 020 HH	
<input type="checkbox"/> 030 Deaf (DEAF)	<input type="checkbox"/> 040 Speech Impaired (SI)	<input type="checkbox"/> 030 DEAF	<input type="checkbox"/> 040 SI	
<input type="checkbox"/> 050 Visually Handicapped (VH)	<input type="checkbox"/> 060 Emotionally Disturbed (ED)	<input type="checkbox"/> 050 VH	<input type="checkbox"/> 060 ED	
<input type="checkbox"/> 070 Orthopedically Impaired (OI)	<input type="checkbox"/> 080 Other Health Impaired (OHI)	<input type="checkbox"/> 070 OI	<input type="checkbox"/> 080 OHI	
<input type="checkbox"/> 090 Specific Learning Disability (SLD)	<input type="checkbox"/> 100 Deaf-Blind (DB)	<input type="checkbox"/> 090 SLD	<input type="checkbox"/> 100 DB	
<input type="checkbox"/> 110 Multi-handicapped (MH)	<input type="checkbox"/> 120 Autism (AUT)	<input type="checkbox"/> 120 AUT	<input type="checkbox"/> 130 TBI	
	<input type="checkbox"/> 130 Traumatic Brain Injury (TBI)			

DISTRICT INFORMATION		
CONTACT PERSON for this Referral (Mr., Ms., Mrs., Dr.)	NAME OF SCHOOL STUDENT ATTENDS	
TITLE	ADDRESS OF SCHOOL	
ADDRESS	CITY/STATE/ZIP CODE	COUNTY
CITY/STATE/ZIP CODE	PHONE	FAX
PHONE	TEACHER (Mr., Ms., Mrs., Dr.)	
E-MAIL	PRINCIPAL (Mr., Ms., Mrs., Dr.)	
STUDENT'S SCHOOL YEAR <input type="checkbox"/> Traditional (SEPT-JUNE) <input type="checkbox"/> Year Round--Dates off Track: <input type="checkbox"/> Winter Break: _____ <input type="checkbox"/> Spring Break: _____	DAILY TIME AT SCHOOL: _____ MINIMUM DAY: _____ DAY OF WEEK: _____ INSTRUCTIONAL TIME: _____	
LEA PROVIDING SPECIAL EDUCATION SERVICES	LEA OF RESIDENCE (If different from service LEA)	
NAME OF AUTHORIZING ADMINISTRATOR OF SPECIAL EDUCATION (Mr., Ms., Mrs., Dr.)		
AUTHORIZING SIGNATURE OF SPECIAL EDUCATION ADMINISTRATOR		
TITLE	PHONE	E-MAIL
ADDRESS	CITY/STATE/ZIP CODE	

## REFERRAL QUESTIONS

<b>Reason for Referral</b>
This section is of particular importance. Clearly state the reasons for the referral, as determined through collaborative efforts of education staff and parents/legal guardians.

<b>DIAGNOSTIC QUESTIONS or AREAS of Concern</b> - Parent/District collaboration to identify specific, educationally-relevant questions/ areas of concern : [Please use a separate sheet of paper as necessary.]

## EDUCATIONAL HISTORY

Date Student Qualified for Special Education Services: \_\_\_\_\_

**Current Individualized Educational Program** IEP Dated: \_\_\_\_\_

Program	Name of Teacher (Print full name)	Phone	E-Mail Address
General Education (full-inclusion)			
Resource Specialist Program			
Special Day Class Type:			
Psychologist			
Speech & Language			
Other DIS:			
Other DIS:			

## List Previous Educational Placements

Class Placement	Inclusive Dates & Grades	School District

**ASSESSMENT HISTORY** (All Sections must be completed.)

**PSYCHOLOGICAL**

***Include copies of reports for all tests administered within the past 30 months.***

Is the student receiving counseling:

- |                            |                          |                          |  |
|----------------------------|--------------------------|--------------------------|--|
|                            | Yes                      | No                       |  |
| Within the school program? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| With mental health agency? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| With private individual?   | <input type="checkbox"/> | <input type="checkbox"/> |  |

If yes, inclusive dates:

Names(s) of Agency and/or Therapist:

Has a functional behavior analysis been completed? Yes  No  **If yes, report must be included.**

Does the student have a behavior support plan? Yes  No  **If yes, report must be included.**

Describe effectiveness of plan.

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**ACADEMIC**

***Include copies of reports for all tests administered within the past 30 months.***

Is the student exempted from the State's STAR assessment? Yes  No

If yes, describe what alternate assessment is in place to measure educational progress:

CAPA Level:

Provide a brief description of current curricula/programs and methods of instruction used to teach skills in reading, math, and written language:

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**SPEECH/LANGUAGE**

***Include copies of reports for all tests administered within the past 30 months.***

Describe materials and strategies used to address language delays/deficits.

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# MOTOR PROFICIENCY

***Include copies of reports for all tests administered within the past 30 months.***

Describe any concerns, interventions and/or accommodations

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## CURRENT FUNCTIONING

Student's strengths:

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Student's interaction with adults:

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Student's interaction with peers:

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Student's overall behavior:

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Does the student have a medical condition affecting educational progress? Yes  No

Please describe:

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Is the student 16 years or older? If yes, attach Individual Transition Plan.

Yes  No

If student is 16 years or older, has (s)he been involved in any work experience programs?

Yes  No

Describe:

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Is the student on track to receive a high school diploma? Yes  No  CASHEE results: ELA: \_\_\_\_\_

Math: \_\_\_\_\_ Other: \_\_\_\_\_

**Please use a separate sheet to provide any additional information you would like to share.**

**Thank you!**

## To District Staff Completing the Application:

It is very important that the items included in the checklist below be included in the application packet. The Application Review Committee meets weekly to review incoming referrals. If any portion of the packet is incomplete, it will result in a delay of the assessment. Also, we have found that most applications that are received after March 15, are scheduled for the following year.

Please work with the student's parents to ensure the diagnostic questions are the result of a collaborative effort to address the specific and prioritized concerns of the entire IEP team. At times, we find parents are unaware of the questions that have been submitted for the assessment.

It is important that you provide the parent with five (5) copies of the HIPPA release form. If the parent will release copies of reports to us directly, this also expedites the assessment scheduling process.

***In order to expedite the assessment process, please enclose copies of any reports (including medical) that you may have on file.*** If you have any questions or concerns about completing the application packet, please call us for technical assistance (559) 243-4047.

### Referral Application Checklist

Please check all items listed to ensure a complete referral application.

- 1. Referral Application - Part I: County/District/School Information
  - \_\_\_ All sections completed
  - \_\_\_ Signature of Authorizing Administrator
- 2. Referral Application - Part II: Parent Information
  - \_\_\_ All Sections Completed
  - \_\_\_ Parent Signatures
  - \_\_\_ Signed authorization to disclose information
  - \_\_\_ Court rulings on custody agreements, educational rights, as appropriate
- 3. Complete Copy of Current IEP- If a new IEP will be developed before the assessment, send a copy of the updated IEP immediately after the IEP meeting.
- 4. Behavior Support/Intervention Plan (as appropriate)
- 5. Most current Psychological Educational Report
  - \_\_\_ Initial \_\_\_ Triennial \_\_\_ Other Date: \_\_\_\_\_

***Most recent testing information which is older than 30 months will not be considered.***
- 6. Copies of any additional testing reports, including Functional Behavior Analysis
- 7. Health History Updates
- 8. Agency Reports (CCS, Regional Center, Mental Health, etc.), as applicable
- 9. Copy of Student's Weekly Schedule, including Designated Instructional Services
- 10. Recent Photograph of Student
- 11. Copy of any Mediation Agreement, as applicable
- 12. Academic Calendar to facilitate scheduling