Specialized Services Department
Committee on Special Education
175 Martin Street
Rochester, NY 14605

Every Child Is A Work Of Art.
Create A Masterpiece

Date Received by Specialize Services Department

_____

Referral for Committee on Special Education

Student's ID:	Student Name:	
Date of Birth:	Gender: Choose an item.	Race/Ethnicity: Choose an item.
Does Student Live with Parents? ☐ YES ☐ No		
If No, With Whom Does the Student Live?:		Relationship:
Parent/Guardian:		
Home Address:		
Home Phone:	Work Phone:	
Dominant Language of the Student:		
Dominant Language of the Parent:	Interpreter Needed:	
Teacher:	School:	Grade:
Referring Person/Title:		
**If information is inaccurate please update with school office personnel*		

Referral Type (*Choose from Drop Down Box)*
Choose an item.

Reason for Referral -Description of Action Proposed or Refused *(Choose from Drop Down Box)*
-Choose an item.

Major Areas(s) of Concern: Check each reason for referring this student:

☐ Communication

- ☐ Communicates Basic Needs and Wants
- ☐ Articulation
- ☐ Knowledge of Sound/Letter Association
- ☐ Other Specify:
- ☐ Expressive Language
- ☐ Voice Quality
- ☐ Receptive Language
- ☐ Other Specify:

☐ Academic Performance

- ☐ Oral Expression
- ☐ Written Expression
- ☐ Reading Comprehension
- ☐ Mathematics Calculation Application
- ☐ Listening Comprehension
- ☐ Basic Reading Skills
- ☐ Reading Fluency
- ☐ Mathematics Reasoning and

☐ Other Specify:

☐ Other Specify:

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Student ID:		Student Name:	DOB:

☐ Health, Vision, Hearing and Motor Abilities

- ☐ Gross Motor Skills
  - ☐ Body Control
  - ☐ Locomotion
- ☐ Vision
- ☐ Developmental History
- ☐ Other Specify
- ☐ Fine Motor Skills
  - ☐ Perceptual Motor
  - ☐ Sensory
- ☐ Hearing
- ☐ Other Specify

☐ Social and Emotional Status

- ☐ Interaction with Peers
- ☐ Interaction with Adults
- ☐ Compliance of Rules
- ☐ Acceptance of Consequences
- ☐ Acceptance to Disappointment
- ☐ Self Help Skills/Play Skills
- ☐ Team/Membership
- ☐ Other Specify:
- ☐ Mood Swings
- ☐ Repetitive Behaviors
- ☐ Self Concept
- ☐ Inactivity or Withdrawal
- ☐ Cooperation
- ☐ Self Control
- ☐ Expression of Feelings/Affect
- ☐ Other Specify:

☐ General Intelligence

- ☐ Understanding New Concepts
- ☐ Interpreting Data to Make Decisions
- ☐ Comparing/Contrasting Ideas of Objects
- ☐ Perceptual Discrimination
- ☐ Other Specify:
- ☐ Predicting Events/Results
- ☐ Problem Solving
- ☐ Applying Knowledge
- ☐ Memory
- ☐ Other Specify:

☐ Work Skills/Technical/Vocational Functioning

- ☐ Attending to Task
- ☐ Following Directions
- ☐ Independent Work Habits
- ☐ Seeking Assistance When Needed
- ☐ Using Research Tools Effectively
- ☐ Maintaining Physical Stamina
- ☐ Having Realist Vocational Goals
- ☐ Other Specify:
- ☐ Punctuality
- ☐ Completing Work
- ☐ Organizing Materials/Belongings
- ☐ Using Technology to Gather/Organize Info
- ☐ Identifying Preferences/Interests
- ☐ Recognizing Personal Limitations
- ☐ Other Specify:

Specialized Equipment Currently Used By Student:		

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Student ID::		Student Name:	DOB:

Explanation of Why Action Is Proposed Or Refused (Choose from drop down box)
Choose an item.

Summary of Standardized Group Test Data (**Description of evaluation procedure, assessment, records, or reports used in the decision to propose or refuse the action**)

Achievement –Include test name, date and score

Reading	Math	ELL Scores
Choose an item.	Choose an item.	Choose an item.
Choose an item.	Choose an item.	Choose an item.
Choose an item.	Choose an item.	Choose an item.

Description of Evaluation Procedure (Choose from Drop Down Box)
Choose an item.

Physical Functioning:

Attach documentation for results of each screening.

VISION	HEARING	MOTOR	SPEECH
Required for all students referred for special education		*Required as determined by the RtI committee*	*Required as Determined by the RtI committee*

VISION	HEARING	MOTOR	SPEECH
Screening Date: ☐ Passed ☐ Failed	Screening Date: ☐ Passed ☐ Failed	Screening Date: ☐ Passed ☐ Failed	Screening Date: ☐ Passed ☐ Failed

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Describe any Existing Health Conditions Below:

Is Student Currently on Medication?: ☐ Yes ☐ No

Summary of Past and Present Support:

Has this student been evaluated for special education previously? ☐ Yes ☐ No
If yes, • When was the student evaluated? • What was the suspected area of disability? Choose an item.
What services is this student receiving or what services has this student received in the past? Fo the services below include year.

ESOL	AIS/RtI	Speech Language	504 Plan	Extended School Year	Gifted and Talented	Other

Involvement with Outside Agency(ies): ☐ Yes ☐ No Agency:

Describe services that are being provided to this student by agency(ies) listed above:

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Check the evaluations that are proposed to be conducted:

Required for all initial evaluations:

☐ Psychological Evaluation

☐ Classroom Observation

☐ Social History

☐ Health Assessment

Indicate additional evaluations required to address areas of suspected disability:

☐ Functional Behavior Assessment (required for all referrals where behavior is impacting learning)

☐Speech/Language Evaluation
☐Occupational Therapy Evaluation
☐Physical Therapy Evaluation
☐Assistive Technology
☐ Other

What uses will be made with this information?

Description of Any Other Option Considered and Reasons Rejected:

☐ There were no other options considered at this time

☐ Other options considered at this time include:

These options were not recommended because:

Description of Any Other Factors that are relevant:

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RtI Team Decision

☐ This referral, as reviewed by the RtI Team and/or Principal Designee, indicates a suspected disability and there is a need for an individual evaluation.
☐ This referral, as reviewed by the RtI Team and/or Principal Designee, does not indicate a suspected disability and there is no documented evidence for an Individual evaluation at this time. However the parent has initiated the
☐ This referral, as reviewed by the RtI Team and/or Principal Designee, does not include sufficient information to determine a suspected disability and the need to initiate a full and individual evaluation. The RtI Team will reconvene on

Date of RtI Team or Principal Designee Decision:	

_____
_____
Signature of Referring Person Date

☐ I verify that this is my signature

☐ I verify that I have reviewed this referral with the Principal/Principal Designee

CSE MEMBERSHIP

Required Staff:

General Ed Teacher: _____

Special Ed Teacher: _____

School Psychologist: _____

As needed:

Other:: _____

Other: _____

Other: _____