



REFERRAL FOR SUPPORT SERVICES

REVISED – MARCH 19, 2009

INTERMEDIATE UNIT I
Fayette-Greene-Washington

I. Service Requested:

- | | |
|--|---|
| <input type="checkbox"/> Assistive Technology * | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Written Expression | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Augmentative Communication | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Assistive Listening (FM) | <input type="checkbox"/> Auditory Processing |
| <input type="checkbox"/> Vision Specific AT | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Occupational Therapy * | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Physical Therapy * | <input type="checkbox"/> Other * (Specify) |

II. Referral Source:

- Pre-referral/Screening
- Initial Referral (Permission to Evaluate) Due Date: _____
- Reevaluation (Permission to Reevaluate) Due Date: _____
- Transfer Student: _____ School District
- Chapter 15
- Chapter 16

III. Student Specific Information:

Student: _____ D.O.B. _____ Grade: _____

Parent/Guardian: _____

Mailing Address: _____

Phone (home): _____ (work): _____

MA Eligible: Yes No

MA# _____ PAsecureID _____

School District of Residence: _____

School Attending: _____ School Phone: _____

Contact Person/Role: _____ * Phone: _____

Contact Person's Email Address: _____

Teacher's Name: _____ Current Program: _____

Teacher's Email: _____

*** LEA Signature (Required)**

Date

Approved By: _____

Supervisor +

Date

Referred To: _____

Support Staff

Date

+ **NOTE:** All Assistive Technology Referrals should be sent to: Assistive Technology Department, IU1 Educational Campus at Laboratory, 99 Manse Street, Washington, PA 15301