**REFERRAL PACKET FOR A SPECIAL EDUCATION EVALUATION**

**Please address and forward completed packets to:**

Michael Lovato- Director of Special Education

Cheryl O’Brien-Executive Secretary

Email submission: [LPSSpedReferrals@lowell.k12.ma.us](mailto:LPSSpedReferrals@lowell.k12.ma.us)

Postal Submission: LPS-Special Education Department

155 Merrimack St. 5th FL

Lowell, MA 01852

**Form Use**-

This google sheet is in view only mode. To complete this form, please go to **File** → **Download**→ **Microsoft Word (.docX).** You will then be able to save and type directly into the form.Please submit the form as an attachment.

**Date Referral Submitted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(LPS Staff Only)***

**SECTION I: Student & Parent/\*Guardian Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name**  **(First, Middle**  **& Last)** |  | | **D.O.B.** |  | |
| **Gender** |  | | **Age** | Yrs \_\_\_\_\_\_\_ Mos \_\_\_\_\_\_ | |
| **Place of Birth (City, State, & Country)** | | | **Race (please circle)**  *Asian Black or African American White*  *NativeHawaiian/Other Pacific Islander*  *American Indian/Alaska Native Two or more races*  **Ethnicity** *-Hispanic or Latino? YES NO*  (please circle) | | |
| **Parent/\*Guardian 1** | |  | **Parent/\*Guardian 2** | |  |
| **Relationship to Student** | |  | **Relationship to Student** | |  |
| **Address** | |  | **Address** | |  |
| **Cell Phone #** | |  | **Cell Phone #** | |  |
| **Home Phone #** | |  | **Home Phone #** | |  |
| **Email** | |  | **Email** | |  |
| **Language(s)**  **spoken\*** | |  | **Language(s)**  **spoken\*** | |  |

***\*If more than 1 language in home, please complete section V.***

|  |
| --- |
| **School or program child currently attends (Please include address, phone number, and contact person)** |
|  |

*\*For Legal Guardians- Court documents will be requested to determine authority for educational signing rights.*

**SECTION II: Referring Party Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Referring**  **Party** |  | **Relationship to Student** |  |
| **How long have you known/worked with the student?** | **Yrs \_\_\_\_\_\_\_ Mos \_\_\_\_\_\_** |
| **Agency**  (if applicable) |  | **Medical Practice** (if applicable) |  |
| **Address** |  | **Phone Number** |  |
| **Email** |  |

**SECTION III: Health Related Needs/Other Information**

Any concerns with students' general health? Yes No Date of last physical examination:

Passed Vision Test: Yes No Date: Examiner:

Passed Hearing Test: Yes No Date: Examiner:

Does the child wear corrective lenses? Yes No

Does the child wear corrective devices to support hearing? Yes No

Medical history: accidents, injuries, surgeries?

Medical Issues (allergies, conditions):

Medical Diagnoses:

Current Medications (type, reason, side effects):

Hospitalizations? Dates / Facility:

**Are there any other medical evaluations scheduled or being scheduled that would be important information for the Evaluation Team? Yes No**

**If yes, what is the reason for the evaluation and type of evaluation being requested?**

**What is the name of the medical examiner / agency conducting the evaluation?**

**DCF Involvement? Yes No**

**(Please attach court mittimus or related legal documentation involving guardianship)**

**SECTION IV: Language Information (if applicable)**

|  |  |
| --- | --- |
| **What is the primary language(s) of each parent/guardian?**  **Parent 1/Guardian 1**    **Parent 2/Guardian 2** | **Who does the child live with ?** (include siblings, other relatives)  **Is a language other than English spoken in your home? Yes No**  **Other language(s) spoken are :** |
| **What language did your child first understand and speak?** | **Which language(s) are spoken with your child and how often?** (*include relatives -grandparents, uncles, aunts,etc.)*  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ seldom /sometimes /often/always**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ seldom /sometimes /often/always** |
| **Which language do you use most with your child?** | **If your child is in daycare / with a babysitter, what language is spoken by the provider?** |
| **Which languages does your child use and how often? (circle one)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ seldom /sometimes /often/always**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ seldom /sometimes /often/always** | **Does your child spend time on a computer, smartphone or iPad? Yes No**  **How often? \_\_\_\_\_ per day \_\_\_\_ per week**  **What websites or games does s/he use or enjoy ?** |
| **Please describe the child’s exposure to the English language.** | **Primary Language of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Primary Language of Parent/Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Will the parent require an interpreter? Yes No** |

**SECTION V: Reason(s) for Referral**

**1. Briefly explain your overall *concerns* with the student’s progress:**

**2. Cognitive Development**

* Is the child able to make changes in their learning when provided teacher modeling and/or demonstration?

Yes No If no, please explain:

* Is the child able to make changes in their learning when the task is broken down into smaller steps / discrete segments?

Yes No If no, please explain:

**3. Social / Behavioral Adjustment Development**

* Circle the child’s current level of play: Solitary Parallel Cooperative
* Has the student been able to follow the school routines?    
   Yes No If no, please explain:
* Does the child participate in counseling, in-home support, or therapy(eg-Family/Individual Counseling, Trauma Services/Assessment, BCBA)? Please describe service(s) including information on duration and frequency. Please provide the name of the therapist/agency and contact information.

**4. Gross Motor / Sensorimotor Development**

*Note: School–based physical therapists provide services in educationally relevant areas in which they can help promote student success and access to the school setting and curriculum.*

**5. Fine Motor/Perceptual Development**

Areas of Concern:

**6. Speech (articulation/intelligibility)**

Does the child’s speech and intelligibility improve when provided adult modeling of correct pronunciation and/or isolated sounds? (please circle) Yes No

**7. Language Development**

|  |  |
| --- | --- |
| Expressive Language-Areas Of Concern: | Receptive Language-Areas of Concern: |

* Check all that apply:

\_\_\_\_ Uses some signs (e.g., all done, more)

\_\_\_\_ Uses gestures (e.g., points to preferred object)

\_\_\_\_ Uses physical communication (e.g., holds hand and brings you to desired object)

\_\_\_\_ Uses single words

\_\_\_\_ Combines 2 words (e.g., “More car,” “Want car”)

\_\_\_\_ Combines 3+ words (e.g., “I want that,” “Mommy, play cars”)

**Attempts to Resolve**

Prioritize how the present problems impact the student’s ability to make progress in age appropriate activities or their current program.

Is attendance impacting the child’s learning? Yes No

Please describe the primary issue impacting learning?

**Other**

Please note any additional concerns not outlined above.

**SECTION VI: Early Intervention Eligibility Criteria**

*If a child received Early Intervention Services, please check the basis for the Early Intervention Eligibility Criteria.*

Please identify established condition(s), established Developmental Delay(s), or at Risk for Developmental Delay and include the name(s) and certification(s) or clinical background of the professional(s) who made this determination.

\_\_**Infants and Toddlers with an Established Condition or Conditions**

*Condition(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name & Credentials of Professionals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_ **Infants and Toddlers with Established Developmental Delay or Delays**

*Established Developmental Delay* (s) *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name & Credentials of Professionals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_ **Infant and Toddlers at Risk for Developmental Delay**

Clinical Judgment *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name & Credentials of Clinician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Was the child deemed ineligible for Early Intervention Services? If yes, basis for ineligibility and date:

Was the child referred to other community agencies or provided information of community resources for being “at risk” for developmental delay? If so, please identify the date of referral, agency or organization.

Has the child been referred to the Head Start Program? Yes No

**SECTION VII:** *Previous Formal Assessments, Progress Monitoring, Screening, Observation or Intervention Data*

**Please identify the assessment(s) completed on the child and the date(s) of administration.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment** | **Date**  **Administered** | **Interpreter**  **Used?** | **Name(s)/ Credential(s) of person(s)  administering assessment** |
| Early Screening Inventory (ESI) |  |  |  |
| Individualized Family Service Plan IFSP & 6 month reviews |  |  |  |
| TS GOLD Individual Child Report |  |  |  |
| Other progress monitoring tools |  |  |  |
| Intervention or support team data |  |  |  |
| Observational Data / TAT |  |  |  |
| Battelle Developmental Inventory 2nd Ed. Normative Update -BDI-2 NU-  *Please circle one below*:  *Complete Inventory OR Screening Test Only* |  |  |  |
| Battelle Developmental Inventory -2nd Edition Normative Update -Spanish Version BDI-2 -NU  *Please circle below*:  *Complete Inventory OR Screening Test Only* |  |  |  |
| Battelle Developmental Inventory -2nd BDI-2  *Please circle below*:  *Complete Inventory OR Screening Test Only* |  |  |  |
| Battelle Developmental Inventory -2nd BDI-2 Spanish Version  *Please circle below*:  *Complete Inventory OR Screening Test Only* |  |  |  |
| ASQ- 3/ASQ-SE |  |  |  |
| DIAL-4 |  |  |  |
| **Other** (please identify assessment tool and version) |  |  |  |

**SECTION VIII: Additional Information from EI Providers**

LAST EVALUATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NEXT EVALUATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The school district is requesting the submission of **all assessments and evaluation reports** completed by the early intervention programs in their entirety.

**EARLY INTERVENTION /Other Provider SERVICE HISTORY & DELIVERY**

Please indicate each service and service delivery information that the child/family has been referred to and/or has received.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Service** | **Referral**  **Date** | **Start**  **Date** | **Frequency** | **End**  **Date** | **Service Provider**  **Address & Phone Number** |
| Assistive Technology |  |  |  |  |  |
| Audiology Services |  |  |  |  |  |
| Family Training, Counseling,  and Home Visits |  |  |  |  |  |
| Health services |  |  |  |  |  |
| Medical Services-diagnostic &  evaluation purposes to determine  child’s EI eligibility |  |  |  |  |  |
| Nursing Services |  |  |  |  |  |
| Nutrition Services/Feeding |  |  |  |  |  |
| Speech and Language Therapy |  |  |  |  |  |
| Occupational Therapy |  |  |  |  |  |
| Physical Therapy |  |  |  |  |  |
| Psychological Services |  |  |  |  |  |
| Service Coordination |  |  |  |  |  |
| Sign Language |  |  |  |  |  |
| Specialized instruction |  |  |  |  |  |
| ABA Services |  |  |  |  |  |

**SECTION LX: Attachment Checklist (to be completed by referring party)**

*\*Please attach all relevant documents.*

***I have attached the following documents:***

**\_\_\_\_\_** COURT DOCUMENTATION (Guardianship)

\_\_\_\_\_ INDIVIDUAL FAMILY SERVICE PLAN

\_\_\_\_\_ BATTELLE DEVELOPMENTAL INVENTORY

\_\_\_\_\_ EARLY INTERVENTION DEVELOPMENTAL PROFILE (MICHIGAN)

\_\_\_\_\_ AGES & STAGES QUESTIONNAIRE

\_\_\_\_\_ PROGRESS NOTES

\_\_\_\_\_ TRANSITION MEETING DOCUMENT

\_\_\_\_\_ SPEECH AND LANGUAGE EVALUATION

\_\_\_\_\_ OCCUPATIONAL THERAPY EVALUATION

\_\_\_\_\_ PHYSICAL THERAPY EVALUATION

\_\_\_\_\_ MEDICAL REPORTS & EVALUATIONS