

# Tillamook School District Special Education Initial Referral Form

Student:		Grade:	DOB:	ID#:
Home School:	Attending school:	Referred by:		Phone #
Parent/Guardian Name:	Other Parent Contact	Contact Number(s): Hm: _____ : Wk: _____		

**PRESENT CONCERNS** (be specific):

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**GENERAL INFORMATION:**

What are the student's strengths/assets?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What building level services have occurred? Attach RTI Intervention Worksheet

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## UTILIZATION OF COMMUNITY RESOURCES:

What community resources have been utilized to assist the student (e.g., mental health services, YST services, etc.)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Describe the results of the interventions:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Does the student have a DSM IV diagnosis? Yes \_\_\_\_ No \_\_\_\_

If yes, please state: \_\_\_\_\_

## ATTENDANCE:

How many schools has the student attended in last 5 years? \_\_\_\_\_

Does the student have a history of excessive absenteeism (in excess of 15 absences a year for the past three years)? \_\_\_\_\_

Has attendance been a problem during the current year? \_\_\_\_\_

## MOST RECENT STATE ASSESMENT SCORES:

Year	Reading	Mathematics	Written Language

## GRADES: (attach grade reports if appropriate)

This Year		Last Year	
Subject	Grade	Subject	Grade


## Considering Special Education in the area of Emotional Disturbance?

No\_\_\_ Yes\_\_\_ If yes, complete the rest of the page.

<b>Suspension/Expulsions:</b>  Been sent to principal's office: In-school suspensions: Out of school suspensions: Expulsions	How many?  How many  How many?  How many?	<b>Counseling:</b> Is he student receiving counseling?  Is this the first year the student behavior has been a problem?  If counselor is outside the school system, has parent given written consent to get information	Yes ___ No ___ If yes, who from?  If no, when did it begin?  If yes, what seemed to be the cause?  Yes ___ No ___
<b>Behavior Interventions:</b> Has data been kept on the behavior?  What happened that caused you to feel behavior intervention was needed?  Does the behavior seem to happen at the....	Yes ___ No ___  Behavior:  Same time? Yes ___ No ___ When?  Same place? Yes ___ No ___ Where?  Around the same person? Yes ___ No ___ Who?  During the same activity? Yes ___ No ___ What activity?	<b>Drugs/Alcohol:</b> Is the student suspected of using drugs or alcohol?  Has the student participated in a Drug/Alcohol Screening?  Is there recent stress or traumatic event in the student's life (divorce, death in the family)?	Yes ___ No ___  Yes ___ No ___  Yes ___ No ___ If yes, explain
<b>List all interventions (not just consequences) that have been tried and if they worked or not. Please attach a copy</b>  Give examples of the student's main behavioral problems:			

Behavior during instruction:

Behavior with peers:

## Considering Special Education in the area of Emotional Disturbance, (continued from page 3)

Please rate this student on his/her behavior. Compare his/her behavior to other students in the class. Circle the correct rating number based on the frequency observed over the past 30 days.

<b>Frequency Intensity</b>	Never a Problem 1	Seldom a Problem 2	Often a Problem 3	Constantly a Problem 4
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BEHAVIOR	RATING	COMMENTS
Physically Aggressive (harmful to others)	1 2 3 4	
Verbally Aggressive (threatening hard to others, menacing)	1 2 3 4	
Anger Outbursts, Tantrums	1 2 3 4	
Harmful to Self (suicidal ideas or plans)	1 2 3 4	
Harmful to Self (non-life threatening self-injury; carving on self, etc.)	1 2 3 4	
Inadequate Self Care/Hygiene	1 2 3 4	
Substance Abuse (tobacco, alcohol, drugs)	1 2 3 4	
Inappropriate Sexual Behavior	1 2 3 4	
Socially Immature	1 2 3 4	
Lying, Denying, Misrepresenting Truth	1 2 3 4	
Withdrawn, Timid, Isolates	1 2 3 4	
Takes Advantage of Others/Exploitive	1 2 3 4	
Allows Others to Take Advantage of Him/Her	1 2 3 4	
Fire Setting	1 2 3 4	
Runaway	1 2 3 4	
Fantasizes	1 2 3 4	
Attention-seeking Behaviors (talks out, calls out, etc.)	1 2 3 4	
Stealing, Cheating	1 2 3 4	
Anxiety, Oversensitive, Crying, Physical Complaints, Depressed	1 2 3 4	
Argues, Talks Back, Complaining	1 2 3 4	
Excessive Energy, (out of seat, overactive)	1 2 3 4	
SOCIAL RELATIONSHIPS	RATING	COMMENTS
Same Sex Peers	1 2 3 4	
Opposite Sex Peers	1 2 3 4	
Adults in Authority Positions	1 2 3 4	
Other Adults	1 2 3 4	

<b>WORK AND STUDY SKILLS</b>	<b>RATING</b>	<b>COMMENTS</b>
Asks for Help	1 2 3 4	
Listens to Teacher	1 2 3 4	
On Task/Works at Desk	1 2 3 4	
Follows Directions	1 2 3 4	
Prepared/Has Materials	1 2 3 4	
	1 2 3 4	

Additional Comments:

## Considering Special Education eligibility in the area of Learning Disability:

**No**\_\_\_ **Yes**\_\_\_ If yes, complete the rest of the page

Check all that apply (in comparison to an average student):

Basic Reading Skills	Math Reasoning
<input type="checkbox"/> Frequent difficulty associating letter to sound	<input type="checkbox"/> Frequent difficulty in serial ordering of numbers
<input type="checkbox"/> Misread words at age/grade level	<input type="checkbox"/> Difficulty with spatial concepts
<input type="checkbox"/> Difficulty sequencing and/or blending sounds	<input type="checkbox"/> Difficulty with concepts of time
<input type="checkbox"/> Guesses at sight words from initial letters	<input type="checkbox"/> Inability to solve word or story problems
<input type="checkbox"/> Poor sight vocabulary	<input type="checkbox"/> Difficulty in applying measurements
<input type="checkbox"/> Unable to apply word analysis skills	<input type="checkbox"/> Cannot infer which mathematical process to apply problem that is stated orally
<input type="checkbox"/> Oral reading slow, laborious or mechanical	
<input type="checkbox"/> Reads unevenly with poor phrasing	
<input type="checkbox"/> Oral reading has frequent omissions, repetitious and substitutions	
Reading Comprehension	Mathematical Calculations
<input type="checkbox"/> Frequent inability to recall facts	<input type="checkbox"/> Difficulty in recognizing/writing numerals
<input type="checkbox"/> Frequent inability to grasp main idea	<input type="checkbox"/> Difficulty with number-numerical relationships
<input type="checkbox"/> Frequent inability to sequence events in reading passage	<input type="checkbox"/> Difficulty in understanding place value and calculation involving regrouping
<input type="checkbox"/> Difficulty relating elements in a story	<input type="checkbox"/> Difficulty in reading numeral and decimal values
<input type="checkbox"/> Difficulty in drawing conclusion and making inferences from material read	<input type="checkbox"/> Poor spatial arrangements of lengthy calculations, as in long division problems

<input type="checkbox"/> Comprehends what is read better than what s/he reads to self	<input type="checkbox"/> Does not know basic addition, subtractions and/or multiplication facts
<b>Written Expression</b>	<b>Listening Comprehension</b>
<input type="checkbox"/> Avoids written work when possible	<input type="checkbox"/> Frequent difficulty in grasping simple word meanings
<input type="checkbox"/> Poor spacing and letter formation	<input type="checkbox"/> Often ignores classroom interactions
<input type="checkbox"/> Unable to stay on the line when writing	<input type="checkbox"/> Does not attend to what is happening in class
<input type="checkbox"/> Inappropriate or insufficient punctuation	<input type="checkbox"/> Often appears confused
<input type="checkbox"/> Poor organization of writing on page	<input type="checkbox"/> Unable to follow classroom discussions
<input type="checkbox"/> Frequent erasures, crossing out staring over	<input type="checkbox"/> Frequently inattentive
	<input type="checkbox"/> Difficulty retaining what is heard
	<input type="checkbox"/> Lips move during silent reading

Additional Comments:

**Considering Special Education eligibility in the area of Other Health Impairment:**

**No\_\_\_ Yes\_\_\_ If yes,**

Please attach Physician's statement.

What are the student's health concerns?

How does it affect the student's academic performance?

**Considering Special Education eligibility in the area of Vision/Hearing:**

**No\_\_\_ Yes\_\_\_ If yes, complete this section.**

Does student appear to have a vision problem which interferes with classroom performance?

Yes \_\_\_ No\_\_\_

Does the student wear glasses?

Yes \_\_\_ No\_\_\_

Does the student appear to have hearing problems with interferes with classroom performance?

Yes \_\_\_ No\_\_\_

Does the student wear a hearing aid?

Yes \_\_\_ No\_\_\_

**Considering Special Education eligibility in the area of Autism:**

Please attach Autism screening checklist.

**Considering Special Education eligibility in the area of Orthopedic Impairment or  
Evaluation in the area of Gross Motor (PT) or Fine Motor (OT):**

Please attach screening form.

**Considering Special Education eligibility in the area of Traumatic Brain Injury:**

Please attach the documentation of the injury.

How does it affect the student's academic performance?

Additional comments: