Date:	

NORTHEAST INDIANA SPECIAL EDUCATION COOPERATIVE
1607 E. Dowling Street
Kendallville, IN 46755
(260) 347-5236 1-800-589-5236 FAX (260) 347-1657

Preschool Referral for Multidisciplinary Educational Evaluation

Student Information:

Student:		**Date of Birth:**		**Sex:**	**M**		**F**	
Address:		**County of Residence:**						
Phone:		**Home:**			**Cell:**			**Work:**		(Indicate order of preference)
Corporation:		**Home School:**		**STN:**				
Referred By:		**e-mail Address:**						

Racial Background:

	American Indian or Alaskan Native		Hispanic/Latino, any race		White
	Asian		Multi-Racial (not Hispanic)		
	Black/African American		Native Hawaiian/Pacific Islander		

Legal Custody:

	Natural Parents		Maternal Parent		Paternal Parent		Legal Guardian		Other Relative		Friend
	Education Surrogate Parent		Other								

Primary Language:

	English		Spanish		Dutch (Amish)		Mandarin		German		Vietnamese		Korean		Japanese
	Arabic		Russian		Serbian		Other (list)		**Limited English Proficient**	Yes		No			

Parent/Guardian Information:

Father's Name:		Work Phone #:		Cell Phone #:	
Mother's Name:		Work Phone #:		Cell Phone #:	
Guardian's Name:		Work Phone #:		Cell Phone #:	

Reason for this referral (check only suspected disability areas):

	Developmental Delay		Speech or Language Impairment*		Intellectual Disability		Multiple Disabilities
	Autism Spectrum Disorder		Deaf or Hard of Hearing		Blind or Low Vision		Orthopedic Impairment
	Transition from First Steps		Move-In		Other:		Other Health Impairment

Specific questions to be answered by this evaluation:

Developmental:

	Gross or fine motor development		Screening		Gross		Fine		Physical Therapy Evaluation		Occupational Therapy evaluation
	Cognitive development		Receptive language development		Expressive language development		Social development				
	Emotional development		Self-help or other adaptive development								

Comments:

***Speech and Language Referrals**:

	Speech problems		Language problems		Speech and language problems

Comments:

Other:

Student Name:		**Date:**	
Has the child attended preschool?	☐ Yes ☐ No	If so, how many hours per week?	
Past Evaluation?	☐ Yes ☐ No	Copy Attached?	☐ Yes ☐ No
First Steps Services?	☐ Yes, currently ☐ Yes, in the past ☐ No	If yes, when/dismissal date	
If current, indicate types of services			
Past Special Education Services?	☐ Yes ☐ No	When:	Where?
Prosthetic devices prescribed?	☐ Yes ☐ No	What type (Glasses, Hearing Aid, etc)?	
Used regularly?	☐ Yes ☐ No		
Language/Speech Impairment (LSI) remediation?	☐ Yes ☐ No	When:	Where:
Describe the child's strengths:			
Describe the concerns of the parent for enhancing the education of the student:			
Based on evaluation data, provide a statement of the student's present levels of academic achievement and functional performance, including how the student's disability/suspected disability affects the student's involvement and participation in appropriate activities.			
Describe the evaluation procedure, assessment, record, report, or other relevant factors used as a basis for proposing to conduct the evaluation:			
The decision to conduct this evaluation was based on:			
Other factors relevant to this referral:			

Must Be Completed By Designated Official

	Initial in box below
1. Current Vision & hearing screening (Attached)	
2. Family background/social history form completed (Attached)	
3. Documentation of Behavioral Problems, Interventions, and Functional Behavioral Assessment for ED Referral (Attached)	
4. Relevant medical data/reports	
5. Referral, 2 pages completed.	
6. Other pertinent documentation to reason for referral	
7. Date Request for Evaluation Initiated – verbal or written ☐ Parent ☐ 1st Steps ☐ School	
8. Date Written Notice of Intent to Evaluate provided to parent	
9. Date Parent Consent received	

Teacher Signature:		**Date:**	
Intake Person/ Principal Signature:		**Date:**	