

SANTA CLARA COUNTY
REFERRAL FOR SPECIAL EDUCATION AND RELATED SERVICES

Page ____ of ____

Student Name: _____ D.O.B. ____ / ____ / ____ Grade: ____

Name of Parent or legal guardian: _____

Address: _____, _____, _____, _____
Street City Zip Code Phone

Person making referral: _____
Name Title

Date parent notified of intent to refer: ____ / ____ / ____
Method of notifying parent of intent to refer:
 Conference Phone call Written

Parent's or adult student's native language or other primary mode of communication if other than English:

Student's native language or other primary mode of communication: _____
=====

Primary Concern Regarding Student: _____

=====

Specific Reasons for Referral:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Written Language | <input type="checkbox"/> Hearing | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Math | <input type="checkbox"/> Self-Help Skills | <input type="checkbox"/> Vision | <input type="checkbox"/> Social/Emotional |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Fine Motor Skills | <input type="checkbox"/> Health | |
| <input type="checkbox"/> Cognitive Functioning | <input type="checkbox"/> Gross Motor Skills | <input type="checkbox"/> Speech/Language | |

Other: _____

General Education Interventions Attempts: If this referral is by an educational representative, describe interventions attempted prior to this referral and attach documentation. (EC 56303) _____

For District Use Only

Date Received: ____ / ____ / ____ Date Assessment Plan due (15 days) ____ / ____ / ____

Received by: _____ Forwarded to: _____

Case Manager: _____