

Wakulla County Schools
REFERRAL FORM/REQUEST FOR INDIVIDUAL EVALUATION

Student: _____ Age: ____ DOB: _____ Race: _____ Sex: _____

School: _____ Grade: _____

Parent's Name: _____

Address: _____ City: _____ State: _____

Home Phone () _____ Work Phone () _____

Student lives with both parents Mother Father Guardian

The following factors have been ruled out as possible causes of the student's failure to respond to interventions:	
<input type="checkbox"/> Poor or inconsistent attendance	<input type="checkbox"/> Recent changes in the family system
<input type="checkbox"/> Socio-cultural differences	<input type="checkbox"/> Recent illness or medical issue
<input type="checkbox"/> Hearing/Vision concerns	<input type="checkbox"/> Limited English Proficiency (LEP)
<input type="checkbox"/> Lack of appropriate instruction (no preschool experience; minimal instruction in math; has not had certain reading components taught, etc.)	

Is this a referral for gifted services? Yes No (*If yes, skip to Reason for Evaluation; Indicate Gifted Referral.*) Has the Child Study Team reviewed the records of strategies and interventions implemented? Yes No

Does MTSS data support the conclusion that the student has failed to progress adequately with all available Tier 3 interventions (insufficient rate of learning OR progress that can only be sustained through ESE services)? Yes No

Parents have been conferring with the team (at least 2 conferences) and are aware of their child's current standing. Yes No

Is this child currently in ESE? Yes No (If yes, what exceptionality(ies) ? _____)

Please include the MTSS data folder, current IEP (if applicable), and any other pertinent information with this request.

Reason for evaluation:

- | | | |
|---|--|--|
| <input type="checkbox"/> Verification of Placement | <input type="checkbox"/> Classroom Behavior Problems | <input type="checkbox"/> Speech/Language Problems |
| <input type="checkbox"/> Intellectual Evaluation | <input type="checkbox"/> Poor Academic Achievement | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Physical Problems | <input type="checkbox"/> Reading Problems | <input type="checkbox"/> Gifted Referral/Screening |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Parent Request |
| <input type="checkbox"/> Initial MTSS data evaluation | | |

Signature of Guidance Counselor/MTSS Facilitator

Approved by ESE Director/Designee Date