**SCHOOL AGE STUDENT SERVICE REFERRAL**



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Date of Request: | | | | |  | | | | | | | | | | | | | | | | | | | | Social Security #: | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | | | | | | | | | Gender: | | | |  | | | | | | | | | | Birth Date: | | | | | | | |  | | | |
| PA Secure ID# | | | |  | | | | | | District of Residence: | | | | | | | | |  | | | | | | | | | | | | Residence Status: | | | | | | | | | | |  | | | | | | | | |
| Person(s) with whom child lives: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the student’s ethnicity? | | | | | | | | | | | Hispanic or Latino Not Hispanic or Latino | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the student’s race? *(select all that apply)* | | | | | | | | | | | | | | | | White Black or African American Asian | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | Native Hawaiian or Other Pacific Islander American Indian or Alaska Native | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the student’s education classification? | | | | | | | | | | | | | | | | | | Regular Ed | | | | | | | | Special Ed | | | | | | | | | 504 Plan | | | | | | | | | | | | | | | |
| Is there another language spoken in the home? | | | | | | | | | | | | | | | | | | Yes No | | | | | | | | If so, what Language? | | | | | | | | |  | | | | | | | | | | | | | | | |
| Is this student or has this student received ESL Instruction? | | | | | | | | | | | | | | | | | | | | | | Yes No | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Student Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | |
|  | | | | | | | | | **(Street)** | | | | | | | | | | | | | | | | | | **(City)** | | | | | | | | | | | | | | **(State) (Zip)** | | | | | | | | | |
| Natural/Adoptive Parent or Legal Guardian: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | |  | | | | |
| Parent Address (if different): | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | |  |
|  | | | | | | | | | **(Street)** | | | | | | | | | | | | | | | | | | **(City)** | | | | | | | | | | | | | | **(State) (Zip)** | | | | | | | | | |
| Home Phone: | | |  | | | | | | | | | | | | | | | | | | | | | | | | Work Phone: | | | | | | |  | | | | | | | | | | | | | | | | |
| Current School: | | | |  | | | | | | | | | | | | | Grade: | | |  | | | Teacher: | | | | |  | | | | | | | | | | | | | | | Phone: | | | | |  | | |
| Student’s Neighborhood School Building: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Referred by: | |  | | | | | | | | | | | | | | | | | | | Phone: | | |  | | | | | | | | | Position: | | | | | | |  | | | | | | | | | | |
| Reason for Referral: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Class Placements**  **ESL**– check if student requires services  **1:1**  **Autism Support *(district based)***  **Autism Support-center-based *(HTA only)***  **Capital Area Mental health Program (CAMhP)**  **Deaf or Hard of Hearing Support**  **Diagnostic Program**  **Diakon/Center Point Day Treatment Prgm**  **Emotional Support**  **Clinical Support**  **Future Ready Work Immersion at PaTTAN**  **Multiple Disabilities Support**  **Penn State Hershey Project SEARCH**  **Non Class Placement Services**    **Blind or Visually Impaired**  Screening  Assessment/Evaluation  Observation/Consultation  Direct Service  Support to School Personnel  Materials Access  **Deaf or Hard of Hearing**  Assessment/Evaluation  Observation/Consultation  Direct Service  Support to School Personnel  Hearing Screening Follow-up    **Direct Educational Services:**  Itinerant Instruction  Instruction Conducted in the Home  Homebound Instruction | | | | | | | | | | | | | | | **Extended School Year**    **FM Assistive Listening System**  **Occupational Therapy**  Assessment/Evaluation  Observation/Consultation  Direct Service  Support to School Personnel  **Orientation & Mobility**  Assessment/Evaluation  Direct Service  Support to School Personnel  **Personal Care Aide (PCA)**  PT <29 hr/wk  FT >29 hr/wk  **Physical Therapy**  Assessment/Evaluation  Observation/Consultation  Direct Service  Support to School Personnel  **Psychological**  Clinical Mental Health Evaluation  School Psychological Evaluation:  ADOS *(Autism Diagnostic Observation Schedule)*  Autism  Deaf or Hard of Hearing  Gifted Screening  Initial Evaluation  Reevaluation/Review  Reevaluation/Test  Visual Impairment  Support to School Personnel | | | | | | | | | | | | | | | | | **School Health Services**  Nursing  Spot Vision Screening  **Social Work**  Direct Service  Support to School Personnel  **Special Ed Coaching**  Autism  Support to School Personnel  Observation/Consultation  Positive Behavior Support  Functional Analysis  Functional Behavior Assessment  Direct Service  Support to School Personnel  Observation/Consultation  **Speech & Language**  Screening  Assessment/Evaluation  Observation/Consultation  Feeding Assessment/Consultation  Direct Service  Support to School Personnel    **Transition Support:**  Support to School Personnel  Work Based Learning Experience  Transition Assessment  **To submit a referral, Email to:**  [**caiureferrals@caiu.org**](mailto:caiureferrals@caiu.org)  **or Fax to:**  **717-732-8425** | | | | | | | | | | | | | | | | | | |

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| **\*\*PLEASE COMPLETE PAGE 2\*\*** |

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| **I understand this will result in a modification to my contract. Please provide this service.**  **Please contact me if this service will result in a modification to my contract** |

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| Authorized Signature | |  | Services requested will be billed to the district making the request | |
| Position |  | | unless an alternate district is identified. |  |

**SCHOOL AGE REFERRAL REQUEST**

**Required Documentation**

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| **Class Placement Services**  **The following documents are required for all Class Placement referrals:**   * Most recent IEP * Most recent ER/RR * Transcripts for grades 9-12 * Most recent report card for grades K-8   **The following documents are requested as soon as possible but are required prior to enrollment:**   * Immunizations/School Health Records * NOREP reflecting new educational placement * Health Plan *(if applicable)* * Student’s school district enrollment form *(necessary for PIMS)* * Student’s Home Language Survey   **The following class placements require additional documentation as noted below:**  **Autism Support:**   * Evaluation Report indicating diagnosis of Autism/PDD   **Deaf or Hard of Hearing Support:**   * Audiologist and/or Otologist report * Communication Plan   **Penn State Hershey Project SEARCH:**   * PSH Project SEARCH Application | **Non-Class Placement**  **Services**  **The following documents are required for all Non-Class Placement referrals unless otherwise noted:**   * Most recent IEP * Most recent ER/RR   **🞶**Permission to Evaluate/Reevaluate for evaluation requests  **The following services require additional documentation as noted below:**  **Blind or Visually Impaired:**   * Medical documentation of Visual Impairment   **Deaf or Hard of Hearing:**   * Audiologist and/or Otologist report * Communication Plan   Hearing Screening Followup**:**   * Student List * No IEP/ER/RR required   **Extended School Year:**   * IEP indicating ESY eligibility and required services * Health Care Plan *(if applicable)* | **Occupational Therapy Evaluation🞶**  **Physical Therapy Evaluation🞶**  **Clinical Mental Health Evaluation🞶:**   * Any previous psychological/psychiatric documents   **School Psychological🞶:**   * Most recent Psychological Eval. Report or ER/RR   **ADOS🞶**:   * ER/RR/IEP if applicable   **School Health Services- Spot Vision Screening**   * Student list * no IEP/ER/RR required   **Special Ed Coaching**  Autism:   * Evaluation Report indicating diagnosis of Autism/PDD   PBS:   * Positive Behavior Support-Functional Analysis🞶 * Positive Behavior Support-Functional Behavior Assessment🞶   **Speech & Language Evaluation🞶:**   * Screening Results |