School District/Public Agency	**Referral - Special Education** 34 C.F.R. §300.301(b)

Name of Student		WISER ID	DOB	Grade	Date
Name(s) of Parent or Guardian		**Name(s) of Parent or Guardian**			
Address (City, State & Zip)		**Address (City, State & Zip)**			
Contact Information		**Contact Information**			
H:	**C:**	**H:**	**C:**		
W:	**Email:**	**W:**	**Email:**		

Reason for Referral

State reason(s) you believe that the child has a disability and needs special education and related services. Explain in detail the child's academic and nonacademic performance. Include any important medical, emotional or other health related information.

Interventions and Effects

Discuss and detail any interventions, services or other programs used to address the child's needs. Include information about the duration of the interventions, services or programs that were attempted and the effects of the interventions on the child's performance, to the extent known.

Name of Student	DOB	Grade

Vision and Hearing Screening

Document the results of vision and hearing screening; any failed portion indicates a failed screening.

Vision Screening **Date Performed: ________________________**			
Vision is: □ CORRECTED (glasses/contacts) □ UNCORRECTED			
	BOTH	**LEFT**	**RIGHT**
Distance Acuity	20/	20/	20/
Near Acuity	20/	20/	20/
Tracking	**□ PASS □ FAIL**		
Stereo Vision	**□ PASS □ FAIL**		
Color Vision	**□ PASS □ FAIL**		
Notes:			

Hearing Screening **Date Performed: ________________________**			
OTOSCOPY:			
PURE TONE RESULTS @ 20 dB	**1.0 kHz**	**2.0 kHz**	**4.0 kHz**
Right Ear	**□ PASS □ FAIL**	**□ PASS □ FAIL**	**□ PASS □ FAIL**
Left Ear	**□ PASS □ FAIL**	**□ PASS □ FAIL**	**□ PASS □ FAIL**
TYMPANOMETRY	**PRESSURE**	**COMPLIANCE**	
Right Ear	**□ PASS □ FAIL**	**□ PASS □ FAIL**	
Left Ear	**□ PASS □ FAIL**	**□ PASS □ FAIL**	
Notes:			

Parent Involvement

Indicate how the concerns have been addressed with parent(s).

Signature of Person Making the Referral:

Signature____ Date_____________________

For Agency Use Only

Name & Title of Public Agency Representative Receiving Referral	**Date of Receipt of Referral**	**Procedural Safeguards Provided to Parent for Initial Referral** 34 C.F.R. §300.504(a)(1)
		By: ___________ Date: ________