



SOUTHWEST SELPA

REGIONAL PROGRAM REQUEST FOR SERVICES

SSID # _____

<input type="checkbox"/> Autism <input type="checkbox"/> Behavior Intervention Support <input type="checkbox"/> Deaf and Hard of Hearing Support	SDC <input type="checkbox"/> Visual Impaired <input type="checkbox"/> Functional Curriculum & Social Skills <input type="checkbox"/> Health Support	EVALUATION <input type="checkbox"/> Deaf and Hard of Hearing <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Orientation and Mobility	ITINERANT SERVICE <input type="checkbox"/> Deaf and Hard of Hearing <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Orientation and Mobility	<input type="checkbox"/> INFANT
--	---	---	--	--

School of Attendance: _____ Disability, if known: _____

Full Name of Pupil: <i>(Last, First, Middle)</i>		Primary Language Student:	Birth Date:
Address <i>(Number, Street, City, Zip)</i>			Home Phone:
Name of Person Child Resides With:	Relationship to Pupil:	Guardian/Parent Work Phone:	
Name of Person Child Resides With:	Relationship to Pupil:	Guardian/Parent Work Phone:	
Parent / Guardian Information <i>(if Different From Above)</i> :		Primary Language Parent / Guardian:	
Parent (s) Address <i>(Number, Street, City, Zip)</i> :			Phone:

Please describe reason for referral (i.e. presenting concern)

DISTRICT CONTACT:

Referred by:	School District	Phone:
Name:	Title:	Email:

SIGNATURES TO INITIATE REFERRAL:

Signature of Parent or Legal Guardian: <i>(Specify)</i>	Date Signed:
Signature of District Director or Authorized Representative: <i>(Title)</i>	Date Signed:

COMPLETE AND INCLUDE THE FOLLOWING WITH YOUR REFERRAL:

	Dated		Dated
A. Parent Questionnaire	_____	F. Hearing / Vision Screening Results	_____
B. Psycho-educational Report	_____	G. Audiogram (if available)	_____
C. Related Service Provider Report	_____	H. Eye Exam (if available)	_____
D. Medical Records	_____	I. Other Pertinent Information (Specify) _____	_____
E. Copy of IEP/IFSP	_____	J. Transportation Form (if requesting regionalized transportation)	_____

NOTE: Incomplete referrals will be returned to sender

Please email completed packet to programreferrals@swselpa.org
 For infant referrals please email packet to infantreferrals@swselpa.org

Date Received: _____

Referred to: _____ Date: _____