SOUTHWEST SELPA

REGIONAL PROGRAM REQUEST FOR SERVICES

SSID # _____

SDC		EVALUATION		ITINERANT SERVICE	
☐ Autism	☐ Visual Impaired	☐ Deaf and Hard of Hearing	☐ AAC	☐ Deaf and Hard of Hearing	☐ INFANT
☐ Behavior Intervention Support	☐ Functional Curriculum & Social Skills	☐ Visual Impairment		☐ Visual Impairment	
☐ Deaf and Hard of Hearing Support	☐ Health Support	☐ Orthopedic Impairment		☐ Orthopedic Impairment	
		☐ Orientation and Mobility		☐ Orientation and Mobility	

School of Attendance: _____ **Disability, if known:** _____

Full Name of Pupil: *(Last, First, Middle)*	Primary Language Student:	Birth Date:
Address *(Number, Street, City, Zip)*		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 *(if Different From Above):*		Primary Language Parent / Guardian:
Parent (s) Address *(Number, Street, City, Zip):*		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: *(Specify)*	Date Signed:
Signature of District Director or Authorized Representative: *(Title)*	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: _____