



SOUTHWEST SELPA

REGIONAL PROGRAM REQUEST FOR SERVICES

SSID # _____

<p style="text-align: center;">SDC</p> <input type="checkbox"/> Autism <input type="checkbox"/> Visual Impaired <input type="checkbox"/> Behavior Intervention Support <input type="checkbox"/> Functional Curriculum & Social Skills <input type="checkbox"/> Deaf and Hard of Hearing Support <input type="checkbox"/> Health Support	<p style="text-align: center;">EVALUATION</p> <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 <input type="checkbox"/> OTHER _____
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Suspected Disability: _____

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 _____	J. Transportation Form (if requesting regionalized transportation) _____

NOTE: Incomplete referrals will be returned to sender

Please email completed packet to programreferrals@swselpa.org

Date Received: _____

Referred to: _____ Date: _____