**REFERRAL FOR SUPPPORT SERVICES**

**Service(s) Requested:**

Auditory Processing (requires normal hearing)

Hearing:

Audiologic Evaluation

Hearing Assistive Technology (FM System)

Hearing Support Services (Teacher of Deaf/HH)

Occupational Therapy\*

Physical Therapy\*

Psychiatric

Social History

Speech/Language

Vision:

Vision Assistive Technology

Vision Support Services (Teacher of Vision)

Other: Specify

**Referral Source(s):**

Pre-referral Screening

Consultation (specify for which service(s), if more than one selected)

Initial Referral (Permission to Evaluate) ER Due Date: ­­­­

Reevaluation (Permission to Reevaluate) RR Due Date:

Transfer Student Previous District/State

Chapter 16

**Student Specific Information:**

Student Name: DOB: Grade:

Parent/Guardian:

Mailing Address:

Parent/Guardian Phone: (H) (C) (W)

PA Secure ID: School District of Residence

School Attending: School Phone:

Contact Person/Role: Phone:

Contact Person e-mail address:

Teacher: Teacher e-mail:

**\*LEA SIGNATURE (REQUIRED) DATE**

*To be completed by IU1 Department Supervisor:*

**APPROVED BY:**

**IU1 SUPERVISOR’S SIGNATURE DATE**

**ASSIGNED TO:**

**SUPPORT STAFF NAME DATE**

**SUPPORT STAFF NAME DATE**

**Rev.** 01/07/2021 yp/te