**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