Carver-Scott and MN River Valley Educational Cooperatives
Program/Services Referral

Student Referred:			**Date of Referral:**
Birthdate:	**Age:**	**Grade:**	
Parent/Guardian:		**Telephone:**	**Work Number:**
Address:			
Referred by:			**Telephone:**
School/Program:		**Resident District:**	**Serving District:**

Program/Services Referral: Please attach current IEP and Assessment Report

Special Education Programs	**Special Services**
☐ Ascent Junior High ☐ Passages ☐ Stepping Stones ☐ Transition ☐ River Valley High School ☐ ASD Programs ☐ DCD/ ASD Programs ☐ Wings/ Oasis ☐ JHS PLUS Or ☐ Consultation with Behavior Interventionist Fax or email these referrals to **Barb Bahnson at 952-492-3880/** **bebahns@mrvsec.k12.mn.us**	☐ A.T. Consultant ☐ Autism Consultant ☐ OT ☐ PT ☐ Teacher of Physically Impaired ☐ Speech/Language ☐ Audiologist ☐ DHH Fax/ email these referrals to **Chris Hansen** at **952-567-8231/ chansen@cseced.org** **Reason for Referral :** ☐ **Initial evaluation** ☐ **Re-evaluation** ☐ **Consultation/ Services:**

Has the parent or legal guardian of the student been notified of the referral to a CSEC/ MRVSEC program? _____

Special Education Director: **Date:**

District Building Administration: **Date:**

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Complete page 2

STUDENT STRENGTHS – check all that apply

Listens	Asks for help	Follows Instructions
Attendance	Completes assignments	Sets goals
Stays on task	Expresses feelings	Understands others feelings
Deals with anger constructively	Accepts consequences	Solves problems
Interested in learning	Shares Ideas	Works cooperatively
Gets along with Peers/Adults	Uses self control	Stays out of fights
Passing grades	Sports	Written expression
Gifted academic performance	Communication skills	Honesty
Accepts responsibility for own behaviors		

Other/Comments:_____

_____

_____

STUDENT CONCERNS: check all that apply and provide dates and documentation

Socially isolated	Poor self concept	Withdrawn
Pattern of poor peer relationships	Self mutilation	Fighting/Assaultive
Disruptive (classroom/school)	Tobacco Use	Alcohol/Chemical abuse
Suicidal	Pattern of ISD, ISS, OSS	

Other/Comments: _____

_____

_____

TRUANCY – Has truancy been filed? Yes or No If yes, date of filing _____

COMMUNITY/LEGAL PROBLEMS - Yes or No
If yes, what is the name and phone of the Probation Officer _____ Phone: _____

OTHER AGENCY INVOLVEMENT: _____

Please complete for DHH/ Audiology Services:

Medical Information (Please check all that apply)

☐ Frequent colds and upper respiratory infections	☐ Allergies	☐ Wax build-up
☐ Eardrum perforation	☐ Tonsillitis and adenoiditis	☐ Ringing in ears
☐ Dizziness	☐ High fever	☐ Meningitis
☐ Head injury	☐ Headaches	

☐ Permanent hearing loss: Degree: _____ Onset: _____

Cause: _____Hearing aid use ☐ Yes ☐ No

☐ Ear surgery: Type: _____ Ear:_____ Date:_____

☐ Ear infections/ middle ear fluid: How many: _____ Last episode: _____

Treatment: _____

☐ Other medical concerns, developmental delays or significant illnesses (please describe):

Name of physician/ ENT/ audiologist: _____

Developmental Information (Please check all that apply)

☐ Daydreams or inattentive	☐ Asks for repetition	☐ Turns one ear to listen
☐ Fails to respond to questions/ instructions	☐ Misunderstands continually	☐ Watches speaker's face
☐ Confuses words that sound alike	☐ Is a behavior problem	☐ Speech articulation difficulties
☐ Unusually high or low pitched voice	☐ Delayed language	☐ Speaks abnormally softly or loudly

Additional Comments: