

REFERRAL FOR SPECIAL EDUCATION EVALUATION

Form R-1 (Rev. 05/2022)

MINOCQUA J1 SCHOOL DISTRICT

Initial

Reevaluation

Name of child (Last, first, middle)		DOB	Grade	School	WISEid
Gender:		Race (Ethnicity Code):		Age:	
Student's native language or other primary mode of communication if other than English (specify):					
Name of parent or legal guardian		Address (Street, city, state, zip)		Telephone area/no.	
Parent's native language or other primary mode of communication if other than English (specify):					
Is an interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Person making referral/title			Date and method of notifying parent of intent to refer:		
			Date		
			<input type="checkbox"/> Conference <input type="checkbox"/> Phone Call <input type="checkbox"/> Written		

Date referral received by school district/LEA _____ (month/day/year)

The date the district receives the referral begins the 15 business day deadline by which to complete the review of existing information and to notify the parents of whether additional assessments are needed. In completing the following information, consider concerns about the student's academic and functional performance that affect access, engagement and progress in age/grade level general education curriculum, instruction, environment, or other school activities. For additional information, see [Guide to Special Education Forms](#).

1. Describe why you believe this student has a disability:

2. What are your areas of concern (e.g., academics, cognitive learning, communication, independence and self-determination, physical/health, social and emotional learning)?

- | | | |
|--|---|--|
| <input type="checkbox"/> Academic/pre-academic delays | <input type="checkbox"/> Visual Problem | <input type="checkbox"/> Physical/Medical Problems |
| <input type="checkbox"/> Problems with Learning | <input type="checkbox"/> Communication Problems | <input type="checkbox"/> Sensory/Perceptual skills |
| <input type="checkbox"/> Behavioral - Emotional Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Delayed self-help skills |
| <input type="checkbox"/> Other: Specify | | |

3. If known, include information about any of the following:

a. Early learning or academic achievement (including early literacy or reading achievement):

b. Functional performance (e.g., cognitive learning, communication, independence and self-determination, social and emotional learning):

c. Relevant medical information (physical/health including vision and hearing):

d. Programs, services, or interventions that have been used to address this student's needs and the results of such interventions (including academic or behavior interventions and assistive technology):