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SOUTH BEND COMMUNITY SCHOOL CORPORATION

Special Education Services
215 S. Dr. Martin Luther King Blvd., South Bend, IN 46601
574-393-6119; Fax 574-283-8105

Date *Written Notice* rec'd by certified personnel
_____

REFERRAL FOR INITIAL MULTIDISCIPLINARY TEAM EVALUATION (50 day timeline)

All Grades

The referral for multidisciplinary team evaluation may be initiated by a parent/guardian or by school/public agency personnel. If a parent makes a request, the school has 10 instructional days to provide the parent with Written Notice stating that they propose or refuse to conduct the evaluation. At that time, parental consent for the evaluation may be sought. All referrals must be screened by school personnel for completeness. Incomplete referrals will be returned to obtain necessary information**.**

****The case conference committee meeting has been scheduled for:**
(Date)_____ (Time)_____(Location)_____

***This conference must be scheduled at the time of this referral. Be sure to inform all CC members immediately. A formal Notice of Case Conference must still be sent prior to the scheduled CC.*

This referral has been reviewed for completeness: _____
Principal Signature required

FOR OFFICE USE ONLY

Date rec'd-certified personnel: _____
50 instructional days: _____
45 instructional days: _____

Attachments
☐ Gen. Ed. Intervention Team Forms
☐ Outside psych. Evaluation
☐ Academic Record/Test Record

Rec'd in office: _____
*Parent requests meeting five (5) days prior: Yes ☐ No ☐
Assigned to: _____
Date of Meeting w/Psych: _____

Student _____ Birth Date _____ Age _____

Student ID # _____ STN# _____ Ethnic Code Choose Below Sex ☐ M ☐ F

Parent/Guardian Name _____

Street Address _____ City _____ Zip _____

Mother's home phone _____ Father's home phone _____

Mother's cell phone _____ Father's cell phone _____

Mother's email address _____ Father's email address _____

School *(attending)* _____ Home School (if different) _____

If private/parochial school, provide school's address _____ Zip _____

Phone # _____

Teacher _____ Grade _____ Home Room No. _____

Referral Source: ☐ Parent ☐ School/Agency Contact person's email _____

Date of Referral _____

Rev. 8/16

REASON FOR REFERRAL: To be completed by person referring the student for an evaluation.

The student is being referred for a multi-disciplinary team evaluation because of a suspected disability. The student's educational or functional performance is ***significantly impaired*** due to:

☐ Academic difficulties in the areas of:

- ☐ Reading: *(Describe)* _____
- ☐ Math: (*Describe*) _____
- ☐ Written Expression: (*Describe*) _____
- ☐ Other: (*Describe*) _____

☐ *Behavioral/emotional difficulties: (*Describe*) _____

_____

**Attach Functional Behavioral Assessment and Behavior Intervention Plan*

☐ Physical/medical diagnosis: (*Describe*) _____

_____

The suspected disability is: _____

What questions would you like to have answered as a result of this evaluation?

PERMANENT RECORD INFORMATION *(To be completed by principal or designee)*

List student's previous schools: _____

_____

Has the student been retained? Yes ☐ No ☐ In what grade(s)? _____

If yes, for what reason _____

Is the primary language of the student English? Yes ☐ No ☐ If no, list primary language _____

Date of last vision check _____ Prescribed glasses? Yes ☐ No ☐ Far sighted ☐ Near sighted ☐

Date of last hearing check _____ Results: _____

Has a previous psychological (M-team) evaluation been conducted? Yes ☐ No ☐

Date of previous psychological (M-team) evaluation _____ By whom? _____

(Attach a copy if evaluation was not conducted by SBCSC)

Does the student receive speech/language therapy? Yes ☐ No ☐ *If yes, SLP must complete the section below*

SPEECH-LANGUAGE PATHOLOGIST'S REPORT (*If Applicable*)

Name of Speech-language Pathologist _____

Therapy began_____Frequency/Duration of therapy _____

Test results/date _____

Current goals _____

Describe behavior during therapy _____

Copies of the Academic Record and the Test Record from the cumulative folder and General Education Intervention Forms must be attached to this referral.

Clear Form

RETURN TO: _____ **BY** _____

PSYCH DATE RECEIVED _____

CLASSROOM TEACHER COMPLETES THIS SECTION

Student's Name: _____ **School:** _____

Name of Teacher(s) providing information _____ Class/Grade: _____

How long have you had this student in your class? _____

Primary reason for concern? _____

What supports does the student receive? *(check all that apply)*

☐ Resource Pull-Out ☐ Paraprofessional ☐ SpEd. co-teacher ☐ Title 1 Aide

☐ Title 1 Intervention specialist ☐ ELL Tutoring ☐ Skills Trainer ☐ Social Worker visits

☐ Speech ☐ Other _____

Pertinent Information

Does the student wear glasses? ☐ Yes ☐ Sometimes ☐ No Hearing Aids? ☐ Yes ☐ No

Does the student have medical equipment? *(wheelchair, FM, etc.)* ☐ No ☐ Yes (Specify) _____

Does the student take medication in school? ☐ Don't Know ☐ No ☐ Yes (Specify) _____

School Skills/Work Habits

Number of Absences _____ Numbers of Tardies _____

Has the student's grades/work quality declined ☐ No ☐ Yes (Specify) _____

KEY: N/O= Not Observed S= Sometimes O= Often				
	N/O	**S**	**O**	**Comments**
Turns in assignments on time	☐	☐	☐	
Pays attention in class	☐	☐	☐	
Maintains an organized work space	☐	☐	☐	
Uses class time productively	☐	☐	☐	
Remains seated when requested	☐	☐	☐	
Easily frustrated or gives up	☐	☐	☐	
Completes assigned tasks independently	☐	☐	☐	
Completes work accurately	☐	☐	☐	
Rushes through work	☐	☐	☐	
Is motivated to do work in class	☐	☐	☐	

Asks for help when needed	☐	☐	☐	
Enjoys being in class	☐	☐	☐	
Inconsistent performance	☐	☐	☐	

Other Comments related to student's Work Habits: (consistency with work, test performance, etc).

Social Skills / Behavior

Has this student been suspended ☐ No ☐ Yes *(how many days)* _____

Reasons for suspension _____

Does this student have a behavior plan? ☐ No ☐ Yes *(provide copy)*

Have there been any recent changes to the student's behavior/academics ☐ No ☐ Yes ☐ N/A

_____

Describe the positive characteristics and strengths of this student. Be specific.

_____

Describe the student's classroom behavior:

_____

Describe how the student interacts with peers and adults:

_____

Describe the student's social skills:

_____

Describe the student's ability to communicate in the classroom:

_____

Describe the consequences used to modify behavior *(e.g. sent to office, buddy room, detention, behavior chart, behavior contract, token economy etc.)*:

_____

Within a typical week, how many times have you used the above consequences?

_____

Please indicate the actual observed behavior of the student by checking the boxes below.

KEY: N/O= Not Observed S= Sometimes O= Often				
	N/O	**S**	**O**	**Comments**
Generally cooperative	☐	☐	☐	
Displays mood swings	☐	☐	☐	

Dramatic or attention seeking	☐	☐	☐	
Obeys school rules and authority	☐	☐	☐	
Uses inappropriate language or gestures	☐	☐	☐	
Displays sudden outbursts or temper flares	☐	☐	☐	
Threatens others or is aggressive	☐	☐	☐	
Displays negative verbal or physical actions towards others	☐	☐	☐	
Perfectionistic	☐	☐	☐	
Cries	☐	☐	☐	
Anxious or nervous	☐	☐	☐	
Withdrawn or a “loner”	☐	☐	☐	
Empathetic	☐	☐	☐	
Displays hostile/violent themes in work	☐	☐	☐	
Compulsive or obsessive	☐	☐	☐	
Flexible with changes in routine	☐	☐	☐	
Seldom expresses feelings	☐	☐	☐	
Communicates needs clearly/ Advocates for self	☐	☐	☐	
Included by peers	☐	☐	☐	
Takes responsibility for actions	☐	☐	☐	
Talks about sex or displays sexual themes in work	☐	☐	☐	
Talks about death or suicide	☐	☐	☐	
Engages in self-harm	☐	☐	☐	
Has good personal hygiene	☐	☐	☐	
Wets or soils clothes	☐	☐	☐	
Frequent visits to nurse or Social Worker	☐	☐	☐	

Eats/chews inedible materials	☐	☐	☐	
Other:	☐	☐	☐	

List behavior intervention(s) attempted *(e.g., Behavior Contracts, ZONES of Regulation, etc.):*

Intervention	Duration	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

Academic Progress

Please indicate which of the following accommodations you have attempted with the student:

	Haven't Tried	Times Tried	Result?
Extended Time			
Read Aloud of test items			
Repeating directions			
Reduction of choices			
Use of Calculator			
Modify format			
Modified Work Plan			
Use of Agenda			
Shortened tasks			
Additional time			
Extra Credit			
"Re-Do" missed items			
Provide personal copies			
Others: List book/pg #			

Reading

Benchmark Score Pick below _____ Proficiency _____

What specific skills can the student perform independently (e.g. decoding, comprehension, blending, phonemic awareness) _____

_____

What age/grade level specific skills in reading does the student lack? _____

_____

List intervention(s) attempted (e.g., READ180, Repeated Readings, etc.):

Intervention	Duration	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

Math

What specific skills can the student perform independently (i.e. calculation specific skills such as one-to-one correspondence, regrouping, multi-step problem solving, etc.) _____

_____

What age/grade level specific skills in math does the student lack? _____

_____

List intervention(s) attempted (e.g., Touch-Point Math, Cover-Copy-Compare, etc.):

Intervention	Duration	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

Writing/Language Arts

What specific skills, can the student perform independently (i.e. letter formation, encoding, appropriate grammar, punctuation, capitalization etc.) _____

_____

What age/grade level specific skills in writing does the student lack?_____

_____

List intervention(s) attempted (e.g., Peer Tutoring, etc.):

Intervention	Duration	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Subject Area

What can the student do independently? _____

_____

With what does the student need support? _____

_____

List intervention(s) attempted

Intervention	Duration	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate any other information that the multidisciplinary team should know about this student that was not previously covered: _____