

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: _____	Attachments
50 instructional days: _____	<input type="checkbox"/> Gen. Ed. Intervention Team Forms
45 instructional days: _____	<input type="checkbox"/> Outside psych. Evaluation
	<input type="checkbox"/> Academic Record/Test Record
Rec'd in office: _____	Assigned to: _____
*Parent requests meeting five (5) days prior: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Meeting w/Psych: _____

Student _____ Birth Date _____ Age _____

Student ID # _____ STN# _____ Ethnic Code _____ 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 _____

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.

RETURN TO: _____ BY _____

PSYCH DATE RECEIVED <hr/>

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 (DIBELs/mClass/Acuity/Read180) _____ 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: _____
