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| **STUDENT NAME:**  | **SIMS:**  |
| **PARENT/GUARDIAN NAME:**  | **PHONE:**  |
| **ADDRESS:**  | **WK PHONE:**  |
| **SCHOOL DISTRICT:**  | **SCHOOL:**  |
| **DOB:**  | **AGE:**  | **GRADE:**  |
| **GENDER:** \_\_\_\_\_\_\_\_\_\_\_ | **RACE:** \_\_\_\_\_\_\_\_\_\_\_ |

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| Name of referring person: | Date of referral: |

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| Is the student’s current teacher/teachers certified?[ ]  No [ ]  Yes | Does the student receive Title services? [ ]  No [ ]  YesSubject area(s) [ ]  Reading [ ]  Math [ ] Other: Date services began:  |
| Is the child on medication? [ ]  No [ ]  YesMedical Concerns(ex. Has the child been diagnosed with a medical condition, such as vision or hearing loss?):  |

**Describe the strengths of the student:**

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**Mark the areas of concern this referral will address:**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Reading Comprehension |  | Basic Reading Skills |  | Reading Fluency Skills |  | Pre-Reading Skills |
|  | Written Expression |  | Math Calculation |  | Math Problem Solving |  | Early Math Skills |
|  | Oral Expression |  | Listening Comprehension |  | Communication |  | Adaptive/Daily Living Activities |
|  | Behavioral/Emotional |  | Social |  | Gross Motor |  | Fine Motor |
|  | Hearing |  | Vision |  |  |  | Early Childhood Cognitive |
|  | Other: |

**List each area of concern for the student:**

(If behavior is an area of concern - include description of behavior, frequency, and duration)

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| **Area of concern:** |
| Describe how the concern affects the child’s learning: |
| Describe interventions attempted and how the success of those interventions was measured: |
| List any assessments or other data that the district is using to determine this area as an area of need: |

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| **Area of concern:** |
| Describe how the concern affects the child’s learning: |
| Describe interventions attempted and how the success of those interventions was measured: |
| List any assessments or other data that the district is using to determine this area as an area of need: |

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| **Area of concern:** |
| Describe how the concern affects the child’s learning: |
| Describe interventions attempted and how the success of those interventions was measured: |
| List any assessments or other data that the district is using to determine this area as an area of need: |

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| Date of conference held with person making the referral: Method: Teacher information: Review of student record (i.e. current grades, attendance record, enrollment gaps, various school enrollments, retention information, State and District-wide Assessment data, etc.):  |
| Based upon a review of all referral information, potential areas of disability to evaluate are: |
| [ ]  Specific Learning Disability[ ]  Cognitive Disability [ ]  Autism Spectrum Disorder  | [ ]  Speech/Language Impairment [ ]  Emotional Disability [ ]  Developmental Delay (ages 3 through 8 only)  | [ ]  Orthopedic Impairment [ ]  Traumatic Brain Injury [ ]  Other Health Impaired | [ ]  Vision Loss [ ]  Hearing Loss[ ]  Deafness[ ]  Deaf-Blindness  |
| Refer to the South Dakota Eligibility Tools and Resources Guide for testing areas required to determine eligibility. |
| Parent contacted: (Date) Parent Input: If this was a parent referral, and the district determines evaluation is **not** necessary, Prior Written Notice was sent to parents: (Date)  |