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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: |

|  |  |
| --- | --- |
| Is the student’s current teacher/teachers certified?  No  Yes | Does the student receive Title services?  No  Yes  Subject area(s)  Reading  Math Other:  Date services began: |
| Is the child on medication?  No  Yes  Medical 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:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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: |

|  |  |  |  |
| --- | --- | --- | --- |
| 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) | | | |