ARLINGTON
Public Schools

To complete this form electronically, it must be opened in ***Adobe Reader***!

Referral for Special Education Evaluation

School

Teacher

Student's First Name

Middle Name

Last Name

Date of Birth

Gender

Parent/Guardian Legal Name

Primary Phone

Cell Phone

Address

City

State

Zip

Mailing Address (if different)

City

State

Zip

Person making request

Relationship to student

Date referral discussed with parent

Phone call

In person

Note

Other

Review of files:

Previous referral for Special Education?

Date and disposition of referral:

B-3 services? ☐ Yes ☐ No

If yes, where?

If yes, what areas served in?

☐ Cog ☐ SLP ☐ Motor ☐ Adaptive ☐ Social

Family Resource Coordinator Name/Phone

Birth-3 Standardized Test Results

Previous remedial services? ☐ Yes ☐ No Retained? ☐ Yes ☐ No What grade?

Date and description of services

Date	Assessment	Subject	Score	Passed (Y/N)

Area of focus	Intervention	By Whom?	Start date	Times per day/week	Results *(attach supportive data if needed)*

Please describe the student's strengths and area of proficiency:

Please specifically describe the areas of concern for this student:

Indicate any general health, vision, or hearing difficulties:

What additional interventions, resources, or assistance do you need to help this student succeed?

Referred by

Position

Date

Reviewed by Building Administrator

Date

Signature of Building Administrator

Date