

# REFERRAL FOR SPECIAL EDUCATION AND RELATED SERVICES

Form R-1 (Rev. 05/2017)

## NORTHERN OZAUKEE SCHOOL DISTRICT

Name of child (last, first, middle)	DOB	Grade	School	WISEid (if known)
Name of parent or legal guardian		Address (street, city, state, zip)		Telephone area/no.
Person making referral/title			Date and method of notifying parent of intent to refer Date ____ / ____ / ____ (month/day/year) <input type="checkbox"/> Conference <input type="checkbox"/> Phone call <input type="checkbox"/> Written	
Parent's native language or other primary mode of communication, if other than English (specify): Is an interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Student's native language or other primary mode of communication, if other than English (specify):				

**Date referral received by school district/LEA** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (month/day/year)

The date the district receives the referral begins the 15 business day deadline by which to complete the review of existing information and to notify the parents of whether additional assessments are needed.

1. State the reasons you believe this child has a disability (impairment and a need for special education):

2. Include information about any of the following, if known:

a. Academic/pre-academic achievement (including reading achievement or early literacy):

b. Functional performance (including behavior):

c. Relevant medical information (including vision and hearing):

d. Special programs, services, or interventions used to address this student's needs and the results: