MCIU MONTGOMERY COUNTY INTERMEDIATE UNIT 23
2 West Lafayette Street | Norristown PA 19401 | 610-755-9400 | www.mciu.org

STUDENT REFERRAL TO MONTGOMERY COUNTY INTERMEDIATE UNIT

Please complete ALL sections. Thank you.

DATE: _____ **Student referral for school year:** 19/20
(please choose from the drop down menu)

TO: **Debbie Conaway,** Office of Student Services
Montgomery County Intermediate Unit
2 West Lafayette Street, Norristown, PA 19401
SAReferrals@mciu.org or by fax: 1-888-965-4238

FROM: _____ (Name) _____ (Title) _____ (District)

THE STUDENT IS BEING REFERRED TO THE INTERMEDIATE UNIT FOR THE FOLLOWING REASON(S):

_____

STUDENT NAME: _____ (Last) _____ (First) _____ (Middle)

STUDENT PASecureID _____ CURRENT GRADE: _____

DATE OF BIRTH: _____ MALE ☐ FEMALE ☐

ETHNICITY: Please Choose PRIMARY EXCEPTIONALITY: Please choose

PARENT(S)/GUARDIAN(S) Name: _____

ADDRESS: _____ STUDENT ADDRESS (if different from parent) _____

TELEPHONE: _____ TELEPHONE: (if different from parent) _____

E-MAIL ADDRESS: _____

PARENT DISTRICT: _____ STUDENT DISTRICT: (if different from parent) _____

SCHOOL STUDENT CURRENTLY ATTENDING OR LAST ATTENDED: _____

CURRENT SPECIAL EDUCATION SERVICES BEING PROVIDED:

_____

CURRENT BUILDING PRINCIPAL: _____ TELEPHONE/EMAIL _____

CURRENT TEACHER CONTACT: _____ TELEPHONE/EMAIL _____

ALL Placement requests require the following documents:

- Current ER
- Current IEP
- Health Records

+All Anderson referrals for placement require:

- Counselor notes (Regular Education only)
- Discipline/suspension records
- Transcripts
- Free/Reduced Meals Application
- RR/IEP if applicable

ALL Evaluation requests require current:

- Signed Permission to Evaluate
- ER/IEP if already in Special Education

ALL Itinerant Service requests require a current IEP

For all SAIP and BrainSTEPs referrals, please complete **page 3** and provide additional documentation requested.

STUDENT NAME: _____ D.O.B.: _____

DISTRICT IS REQUESTING REFERRAL FOR: (Please **check appropriate program**)

PROGRAMS and SERVICES	**REQUESTED SERVICE**
Adapted Physical Education	☐
Audiological Evaluation	☐
Audiological Itinerant Services	☐
Auditory Processing Evaluation	☐
Autistic Support Program	☐
Bi-Lingual Psychological Evaluation (Spanish)	☐
Bi-Lingual Speech/Language Consultation (Spanish)	☐
Bi-Lingual Speech/Language Evaluation (Spanish)	☐
BrainSTEPs Consultation (complete pg. 3)	☐
Communication & Learning Classroom (K-4 – Life Skills)	☐
Emotional Support at The Anderson School *+see documentation requirements above*	☐
Feeding Consult/Evaluation *(requires swallow test or doctor referral)*	☐
Hearing Evaluation (FHE) *(requires Audiological Evaluation Report)*	☐
Hearing Support – Itinerant	☐
Hearing Support Classroom – K-8 *(requires Audiological Evaluation Report)*	☐
Instruction in the Home/Homebound	☐
Intensive Emotional Support – K-6	☐
Multiple Disabilities Support (K-12)	☐
Occupational Therapy Evaluation	☐
Occupational Therapy Support – Itinerant Services	☐
Orientation & Mobility Evaluation (*requires Vision Examination Report*)	☐
Orientation and Mobility Support – Itinerant	☐
Physical Therapy Evaluation	☐
Physical Therapy Itinerant Services *(requires PT Script)*	☐
Psychological Evaluation	☐
School Attendance Improvement Program (complete pg. 3)	☐
Speech and Language Evaluation	☐
Speech and Language Itinerant Services	☐
Vision Evaluation (FVE) (*requires Vision Examination Report*)	☐
Vision Support Itinerant Services	☐

ASSISTIVE TECHNOLOGY	**REQUESTED SERVICE**
SETT Meeting – One-time	☐
SETT Meeting – Initial plus all follow ups for the current school	☐
Consultative Services – One-time Consult	☐
Consultative Services – Ongoing through school year	☐
FM System Consultation *(requires Audiological Evaluation Report)*	☐
Vision Technology Consultation	☐

STUDENT NAME: _____ D.O.B.: _____

Reason for SAIP Referrals Only

Briefly describe the reason for referral. List areas of concerns in addition to school refusal:

Areas of Concern (check all that apply)

- ☐ Attendance
- ☐ Mental health
- ☐ Behavior
- ☐ Social skills
- ☐ Academic challenges
- ☐ Drugs & alcohol
- ☐ Other (please specify):

Additional Documentation Requirements:

- Signed Parent Consent
- All attendance data (beginning from the date student enrolled in the district as well as prior attendance data if available)
- All educational records including transcripts and evaluation reports, re-evaluation reports, IEPs, 504 Service Agreements, FBAs, if any.
- Health screenings and other health related information if available

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For BrainSTEPs Referrals Only

Instructional Team Members' Names: **Include email addresses for each member**

Team Facilitator/Teacher: _____

LEA: _____ Nurse: _____

SLP: _____ PT: _____

OT: _____ Other: _____

I. Reason for Referral (Please include date of acquired brain injury, type of injury and cause):

II. Pertinent Background Information (Please attach any relevant documents):

III. Services the child is currently receiving: (Type & frequency)

SL: _____ OT: _____

PT: _____ Other: _____

IV. Has parent been informed of request?