

CHILD FIND REFERRAL: PLEASE SEND TO GCSSA OFFICE AS SOON AS POSSIBLE BY FAX: (903-986-3408) OR EMAIL TO vtthornton@sabineisd.org

Staff Member receiving referral: _____ Date of Referral: _____ Campus: _____

Name of Student: First: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ M F SS# _____ Student ID: _____

Grade: _____ Teacher: _____ At this time, is the student enrolled in ___ school; ___ ECI; ___ Private school
___ Residential Facility; ___ Another public school; ___ Preschool/Day Care; ___ Nursing Home; ___ Group Home; ___ Not enrolled

Unique ID: _____ Language student speaks: _____; Language of the Parent: _____

Ethnicity: _____; Race: _____

Who is making this referral? _____ (Cannot be a staff member in special education)
Relationship to Child: _____ (Teacher, Principal, Counselor, Parent, Guardian, Adult Student) If
parents are divorced, which parent can make educational decisions? PLEASE attach a copy of decree. If both parents are
managing conservators, please tell parent making referral that BOTH parents must give consent for testing.

Parent 1: _____ Parent 2: _____

Child resides with: Parent 1 Parent 2 Both Other: _____

Parent 1 Address: _____ Parent 2 Address: _____

Parent 1 Contact Phone: Home: _____ Parent 2 Contact Phone: Home: _____

Work: _____ Work: _____

CELL: _____ CELL: _____

EMAIL: _____ EMAIL: _____

What is the area(S) of suspected disability: (BE SPECIFIC) _____

Programs which to student already attends: 504 (Please attach a copy of 504 information.)

- Rtl (Level _____) (Please attach a copy of Rtl documents.) ESL/Bilingual
 Dyslexia (Year Dyslexia initiated: _____) Other: _____

How did the parent know to make this referral? Physician Teacher Administrator Letter from School

Child Find posters District had refused to evaluate in a prior school year. When: _____ Other: _____

HAS STUDENT PASSED VISION AND HEARING SCREENINGS: Yes No; Date of V/H Screening: _____

Health: _____ If student is below the age of 5 as of the referral date, please check all of the
following options which apply: Referral from ECI Referral to ECI AI/VI below age of 3 Private School
 Attends Daycare Attends PreK No School

TO BE COMPLETED BY SSA STAFF:

STUDENT: _____

DATES TO BE COMPLETED BY SSA OFFICE:

Child Find Sheet reviewed by Director date: _____
Input into Success Ed and given to appropriate staff member: _____

DATES TO BE COMPLETED BY ASSESSMENT STAFF:

DATE PRIOR WRITTEN NOTICE TO EVALUATE SENT: _____

DATE NOTICE OF EVAL, PROCEDURAL SAFEGUARDS, INFORMED CONSENT, PARENT'S GUIDE TO ADMISSION, REVIEW, AND DISMISSAL PROCESS, SHARS NOTICE AND CONSENT AND REFERRAL INFORMATION SENT TO PARENT: _____

DATE OF CONSENT: _____ (Signature by parent)

DATE OF FIEE: _____

DATE OF ARD MEETING: _____; Qualified? _____ DISABILITY: _____

ANY TIMELINE PROBLEMS: EXPLAIN _____

FOR LSSPS AND SLPS ONLY: Amount of time spent on testing: _____; Amt of time spent on report: _____