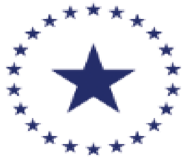

2 West Lafayette Street | Norristown PA 19401 | 610-755-9400 | www.mciu.org

STUDENT REFERRAL TO MONTGOMERY COUNTY INTERMEDIATE UNIT

Please complete ALL sections. Thank you.

DATE: ______________________ **Student referral for school year:** 2022 - 2023
(please choose from the drop-down menu)

TO: Office of Student Services
Montgomery County Intermediate Unit
SAReferrals@mciu.org

FROM: ______________________ (Name) ______________________ (Title) ______________________ (District)

FOR EVALUATION REQUESTS – PLEASE INDICATE DUE DATE:

STUDENT NAME: ______________________ **(Last)** **(First)** **(Middle)**

STUDENT PASecureID ______________________ **CURRENT GRADE:**

DATE OF BIRTH: ______________________ **MALE** ☐ **FEMALE** ☐

ETHNICITY: ______________________ **PRIMARY EXCEPTIONALITY:** White (Non-Hispanic)

SCHOOL BUILDING STUDENT CURRENTLY OR WILL BE ATTENDING: ______________________

SCHOOL BUILDING CONTACT: ______________________ **TELEPHONE/EMAIL** ______________________

STUDENT LUNCHES: FREE ☐ **REDUCED** ☐ **PAY** ☐

PARENT(S)/GUARDIAN(S) Name:

FOSTER PARENT? ☐ **YES** ☐ **NO**

ADDRESS: ______________________

TELEPHONE: ______________________

E-MAIL ADDRESS: ______________________

PARENT DISTRICT: ______________________

STUDENT ADDRESS: ______________________
(if different from parent)

TELEPHONE: ______________________
(if different from parent)

STUDENT DISTRICT: ______________________
(if different from parent)

REQUIRED DOCUMENTATION TO BE EMAILED WITH REFERRAL

ALL Placement requests

- Current ER
- Current IEP
- Health Records

ALL Itinerant Service requests

- Current IEP.

ALL Evaluation requests

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

+All Anderson referrals for placement also require:

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

For all SAIP, BrainSTEPs AND Transition referrals, please complete additional information below and send required documentation

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

CLASSROOM PROGRAMS	**REQUESTED SERVICE**
Autistic Support Program	☐
Communication & Learning Classroom (K-4)	☐
Emotional Support at The Anderson School *+see documentation requirements below*	☐
Hearing Support Classroom – K-12 *(requires Audiological Evaluation Report)*	☐
Intensive Emotional Support – K-6	☐
Life Skills with Behavior Support (5-12+)	☐
Multiple Disabilities Support (K-12+)	☐
OTHER SERVICES	**REQUESTED SERVICE**
Audiological Consultation/Record Review	☐
Audiological Evaluation	☐
Audiological Itinerant Services	☐
Auditory Processing Consultation/Record Review	☐
Auditory Processing Evaluation	☐
Bi-Lingual Psychological Evaluation (Spanish)	☐
Bi-Lingual Speech/Language Evaluation (Spanish)	☐
BrainSTEPs Consultation (complete required information below)	☐
Feeding Evaluation *(requires swallow test or doctor referral)*	☐
Hearing Evaluation (FHE) *(requires Audiological Evaluation Report)*	☐
Hearing Support – Itinerant	☐
Instruction in the Home/Homebound – IN PERSON	☐
• Will the Instruction in the Home student also require related services in the Home? SPEECH ☐ OT ☐ PT ☐ HEARING ☐ VISION ☐	☐
Instruction in the Home/Homebound - VIRTUAL	☐
• Will the Instruction in the Home student also require related services in the Home? SPEECH ☐ OT ☐ PT ☐ HEARING ☐ VISION ☐	☐
Occupational Therapy Evaluation	☐
Occupational Therapy Support – Itinerant Services	☐
Orientation & Mobility Evaluation (FOM) *(requires Vision Examination Report)*	☐
Orientation and Mobility Support – Itinerant	☐
Physical Therapy Evaluation	☐
Physical Therapy Itinerant Services *(requires PT Script)*	☐
School Attendance Improvement Program Evaluation (complete required information below)	☐
Speech and Language Evaluation	☐
Speech and Language Itinerant Services	☐
Transition to Adulthood (complete required information below)	☐
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 year	☐
Consultative Services – One-time Consult	☐
Consultative Services – Ongoing through school year	☐
FM System Consultation *(requires Audiological Evaluation Report)*	☐
Vision Technology Consultation	☐

OTHER SERVICES	☐
Please indicate other services you are requesting that are not listed above. We will make every effort to accommodate your request.	

PLEASE COMPLETE THE INFORMATION BELOW FOR TRANSITION/SAIP/BRAINSTEPS

Transition Program (Please check two services for full day program)									
Adult Training Team (ATT) – Full Day Only				☐	Career Achievement Program – Full Day only				☐
Experience	AM	☐	PM	☐	Internship	AM	☐	PM	☐
Independent Living	AM	☐	PM	☐	Employment	AM	☐	PM	☐
PAES Lab	AM	☐	PM	☐	Mobile PAES Lab	AM	☐	PM	☐
AVIATOR – Vocational Evaluation only		☐							
C.E.O. – North Montco Technical Career Center				☐	C.E.O. – Western Montgomery Career & Technology Center				☐

FOR TRANSITION SERVICES

Student Reading Level Student Math Level

Sessions Attending
Session 1 ☐ Session 2 ☐

Days Attending
2 Days ☐ 3 Days ☐ 5 Days ☐

Does the student have a vocational assessment? Yes ☐ No ☐ (If yes, please submit a copy with the referral)

Does the student have a Behavior Plan? Yes ☐ No ☐ If yes, please submit a copy with the referral

Describe any previous work training/experience or job shadowing:

Please list any medical information we need to be aware of:

Please list any additional information that may be of assistance in providing appropriate programming for this student

EMERGENCY CONTACT PERSON:
EMERGENCY CONTACT PHONE#:

SAIP Referral – Additional Information Required

Briefly describe the reason for referral.

List areas of concerns in addition to school refusal. Check all that apply.

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

SAIP Referral - Additional Documentation Requirements. Please email the following:
-Signed Parent Consent
-All attendance data
-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

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: ____________________