

CHILD FIND REFERRAL FORM



TULARE COUNTY
SPECIAL EDUCATION
SPECIAL EDUCATION LOCAL PLAN AREA

Today's Date: _____

Name of Child: _____ DOB: _____ Primary Language: _____

Name of Person Making Referral: _____ Relationship to Child: _____

Parent/Guardian Name: _____ Phone: _____

Address: _____

Child in school? Yes No Grade: _____ School: _____

Is the child receiving Special Education Services? Yes No School District: _____

Foster Child? Yes No Educational Rights Holder: _____ CVRC? Yes No

Resource Parent Address: _____ Phone: _____

PLEASE COMPLETE EACH ITEM TO THE BEST OF YOUR KNOWLEDGE & DO NOT LEAVE ANY QUESTIONS BLANK

Reason for referral. (Be very specific and describe child):

Describe child's current academic or pre-academic skills:

Does child have any Medical Diagnoses or Health Issues (including vision and/or hearing):

Describe any evaluations the child has had by other agencies or doctors:

Where can copies or reports be obtained?

Indicate area(s) of suspected disability:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Established Medical Condition | <input type="checkbox"/> Other Health Impaired | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Other |
| <input type="checkbox"/> Deaf-Blind | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Speech and Language Impairment | |
| <input type="checkbox"/> Emotionally Disturbed | <input type="checkbox"/> Orthopedic Impairment | <input type="checkbox"/> Traumatic Brain Injury | |

Referral Received by: _____ Date: _____

Spoke with: _____ Date: _____

Sent to DOSE / TCOE: _____

Send completed form to:
Malinda Furtado
malinda.furtado@tcoe.org
(559) 730-2910 ext. 5125