CHILD FIND REFERRAL FORM

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 Name: ______________ 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:

- ☐ *Autism*
- ☐ *Deaf*
- ☐ *Deaf-Blind*
- ☐ *Emotionally Disturbed*
- ☐ *Established Medical Condition*
- ☐ *Hearing Impaired*
- ☐ *Intellectual Disability*
- ☐ *Orthopedic Impairment*
- ☐ *Other Health Impaired*
- ☐ *Specific Learning Disability*
- ☐ *Speech and Language Impairment*
- ☐ *Traumatic Brain Injury*
- ☐ *Visually Impaired*
- ☐ *Other*

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