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
dconaway@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)

DATE OF BIRTH: _____ MALE ☐ FEMALE ☐

STUDENT PASecureID _____

ETHNICITY: _____ PRIMARY EXCEPTIONALITY: _____

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 GRADE: _____

CURRENT SPECIAL EDUCATION SERVICES BEING PROVIDED:

_____

CURRENT TEACHER: _____ TELEPHONE/EMAIL _____

CURRENT BUILDING PRINCIPAL: _____ TELEPHONE/EMAIL _____

OTHER DISTRICT CONTACT: _____ TELEPHONE/EMAIL _____

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

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

PROGRAM/SERVICES	PLACEMENT	SERVICE	EVALUATION/ CONSULTATION
Adapted Physical Education		☐	
Audiological Evaluation			☐
Audiological Services		☐	
Auditory Processing Evaluation			☐
Autistic Support Program	☐		
Bi-Lingual Speech/Language Evaluation (Spanish)			☐
Bi-Lingual Psychological Evaluation (Spanish)			☐
BrainSTEPs Consultation (complete pg. 3)			☐
Emotional Support at The Anderson School+	☐		
Feeding Consultation/Evaluation++			☐
Hearing Evaluation (FHE) (*see below)			☐
Hearing Support Classroom (*see below) (K-8)	☐		
Hearing Support – Itinerant (*see below)		☐	
Instruction in the Home/Homebound	☐		
Intensive Emotional Support – K-6	☐		
Learning Media Assessment for Students w/Visual Impairments		☐	
Communication & Learning (K-4) (Life Skills Support)	☐		
Multiple Disabilities Support (K-12)	☐		
Occupational Therapy (District Served Student)		☐	☐
Orientation & Mobility Evaluation			☐
Orientation and Mobility Support – Itinerant (**see below)		☐	
Physical Therapy (District Served Student)***		☐	☐
Psychoeducational Evaluation			☐
School Attendance Improvement Program (complete pg. 3)		☐	
Speech and Language Evaluation			☐
Speech and Language Support – Itinerant Services		☐	
Vision Evaluation (FVE) (**see below)			☐
Vision Support – Itinerant Services (**see below)		☐	
Vision Technology Consultation		☐	

All referrals for **placement require** the following documents:

- ☐ Current ER
- ☐ Current IEP
- ☐ Health Records

+All Anderson referrals for placement require:

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

All requests for **evaluation require current:**

- ☐ Signed Permission to Evaluate
- ☐ ER if already in Special Education
- ☐ IEP if already in Special Education
- ☐ *Audiological Evaluation Report
- ☐ **Visual Examination Report
- ☐ ***PT Script
- ☐ ++Swallow Test or doctor referral

For all SAIP and BrainSTEPs referrals, please complete page 3 and see additional documentation requirements

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

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? ____

Billing: ☐ **Cost Plan** ☐ **IDEA**