REFERRAL FORM

Regional Direct Service Team
South Central Ohio ESC
522 Glenwood Avenue, New Boston, OH 45662
(740) 354-0270
FAX: (740) 354-0280

Person Making Referral: _____

Reason(s) For Making This Referral? **(Description of Problem)**_____
_____
_____
_____

INDICATE AREAS FOR ASSESSMENT/OBSERVATION/CONSULTATION

_____ Occupational Therapy*

_____ Physical Therapy*
(For OT & PT see NOTE on back of page)

_____ Teachers of Students with Visual Impairments**

_____ Audiology
For ***Audiology,*** indicate below type of assistance requested:
__ Assessment __ Observation __ Consultation

****

STUDENT

Name _____**DOB** _____
Parent/Guardian _____
Address _____
_____
Phone _____
Parent email:_____
Prior Evaluations (Dates/Results)
Vision _____ Hearing _____
Physical Therapy _____
Occupational Therapy _____
Psychological _____

SCHOOL

Building _____ **Grade** _____
Address _____
Phone _____
Teacher _____
Current Special Services_____
ETR DATE: _____ I.E.P. DATE: _____ Disability: _____

Speech/ Language_____
Medical _____ Prosthesis _____
Medications _____
Diagnosis_____

_____ _____ _____ _____
District of Residence **District of Residence Supt. or Designee** **Title** **Date**

(1 copy of assessment Report(s) will be mailed to person signing this referral)

PLEASE MAIL OR FAX TO:

Sarah Rice, Supervisor
Regional Direct Service Team
522 Glenwood Avenue
New Boston, Ohio 45662
FAX: 740.354.0280

***NOTE:** **REFERRALS FOR P.T./O.T:** OT and PT are most often related services. Related services are developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education.

****REFERRALS FOR VISION ASSESSMENT:**

Please refer to the definition of children with visual impairments as defined in Operating Standards for Ohio's Schools Serving Children With Disabilities (Rule 3301-51-01 (F) (3) (m). "Visual impairment" including blindness means an impairment in vision that, even with correction, adversely affects a child's educational performance.

Situations warranting a referral are:

•Evaluation teams suspect a handicapping condition in the area of vision.

OR

•Team members seek assistance with IEP goals and objectives for children ***already*** identified as visually impaired.

**** Before submitting a referral for vision services one of the two following actions should have been completed:**

*The school nurse has completed a vision screening which the student has failed, and/or

*The student has been seen by an ophthalmologist or optometrist and the report may be obtained by the ESC.

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PARENT PERMISSION TO CONDUCT ASSESSMENT

_____ _____
(Student's Name) (D.O.B.)

_____, _____, has requested a member/members of the
(Person making referral) (Title)

Regional Direct Service Team to complete an individual assessment. Information may be used to develop an Individualized Educational Plan (I.E.P) to assist in providing an appropriate educational placement and to provide specific information relevant to your child's education. Specifically, this evaluation is being requested because

_____
_____
_____

The following person/persons will do the assessment:

_____ Occupational Therapist
_____ Physical Therapist
_____ Teacher of Students with Visual Impairments
_____ Audiologist

As the parent, or legal guardian, you have certain legal rights under Section 3301-51-08 (Due Process Procedures) of Ohio's Operating Standards for Ohio's Schools Serving Children With Disabilities. *Results of this assessment will be strictly confidential and will be available only to authorized personnel.* Moreover, your child's placement will not be changed without your permission. Please complete the blanks below.

___ **YES**, the Regional Direct Service Team may conduct an individual evaluation for my child.

___ **NO**, the Regional Direct Service Team **may not** conduct an individual evaluation for my child.

RE: HEARING TESTING! I grant permission for follow-up evaluations to monitor hearing thresholds when test results indicate the need OR when a child is being treated by a physician for ear/hearing dysfunctions, diseases or disorder.

→ → → _____
Parent/Guardian Signature

_____
Relationship to Child

_____
Date

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RELEASE OF INFORMATION

_____, _____
(Student) (DOB)

In order to obtain information which may relate to this assessment, I hereby grant permission for:

_____
(Name, address, and fax number of referring party)

to send or fax all previous assessments, educational and medical records to the Regional Direct Service Team, New Boston, Ohio. Information provided will not be shared without written permission from parent or guardian.

RE: HEARING TESTING!
This release also includes any new medical information following an audiological evaluation and subsequent medical referral. I understand that my permission may also be extended to releasing and receiving information pertaining to my child from my family physician, specialists, or other agencies who may have information relevant to developing an appropriate educational program for my child.

→ → → _____ _____
(Signature of parent or guardian) **(Date)**

Please list other agencies/individuals who may release information about your child to the Regional Direct Service Team. The referral form is **INCOMPLETE WITHOUT THE FOLLOWING IMPORTANT INFORMATION.**

1. **Family Physician:**_____
   Address: _____

2. **Optometrist or Ophthalmologist (Eye):** _____
   _____

3. **Other Agency or Specialist:**_____
   Address: _____