

# Initial Referral to the Multi-Disciplinary Team (MDT) from the School Staff

To: *Chairperson of the MDT*

From: \_\_\_\_\_ School: \_\_\_\_\_ Date: \_\_\_\_\_

Name/Title: \_\_\_\_\_

The following student is being referred to the MDT for suspicion of a disability:

Student Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Program Placement: \_\_\_\_\_

Teacher (Elem): \_\_\_\_\_ Guidance Counselor (Secondary): \_\_\_\_\_

*National Association of Special Education Teachers*

**Reasons for Referral: Describe the specific reason and/or needs that indicate the suspicion of a disability. Specify reason why referral is considered appropriate and necessary.**

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**Describe recent attempts to remediate the pupil's performance prior to referral, including regular education interventions such as remedial reading and math, teaching modifications, behavior modifications, speech improvement, parent conferences, etc. and the results of those interventions.**

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**Do you have a signed Parent Assessment Plan?** \_\_\_Yes\_\_\_No (If yes send copy attached)

**Is there an attendance problem?** Yes\_\_\_No\_\_\_

**Language Spoken at home?** \_\_\_\_\_

**Did student repeat a grade?** Yes\_\_\_No\_\_\_If yes, when?

**Is an interpreter needed?** Yes\_\_\_No\_\_\_Deaf:

**Is a bilingual assessment needed?** Yes\_\_\_No\_\_\_ If yes, what language

**Language spoken at home:**\_\_\_\_\_

**Is student eligible to receive ESL (English as a Second Language) services?** Yes\_\_\_No\_\_X\_\_\_

**If yes, how many years receiving ESL services?** \_\_NA\_\_ If yes, determine how student's educational, cultural and experiential background were considered to determine if these factors are contributing to the student's learning or behavior problems. \_\_\_\_\_

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TEST SCORES WITHIN LAST YEAR

(i.e. Standardized Achievement, Regents Competency etc)

TEST NAME	AREA MEASURED	PERCENTILE SCORE	COMMENT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has school staff informed parent/guardian of referral to CSE? Yes\_\_\_No\_\_\_

By whom? \_\_\_\_\_

What was the reaction of the parent/guardian to the referral? \_\_\_\_\_

To be Completed by School Nurse-Medical Report Summary

Any medication? Yes\_\_\_No\_\_\_ If yes, specify:

Health Problems? Yes\_\_\_No\_\_\_ If Yes Specify:

Scoliosis Screening: Positive\_\_\_Negative\_\_\_

Date of Last: Physical:\_\_\_\_\_ Vision results:\_\_\_\_\_ Hearing Results:\_\_\_\_\_

Relevant Medical information: \_\_\_\_\_

Nurse Teacher signature: \_\_\_\_\_

Principal's signature: \_\_\_\_\_

To Be Completed By the Appropriate Administrator

Date received:\_\_\_\_\_ Signature:\_\_\_\_\_

Chairperson: \_\_\_\_\_

*National Association of Special Education Teachers*

**Date Notice and Consent Sent to Parent/Guardian:**\_\_\_\_\_

**Date Parent Consent for Initial Evaluation Rec'd:**\_\_\_\_\_

**Date Agreement to withdraw Referral Received:**\_\_\_\_\_

**Projected Eligibility Meeting Date:**\_\_\_\_\_

**If eligible, projected date of implementation of services:**\_\_\_\_\_

**Projected Eligibility Board of education meeting date:**\_\_\_\_\_