EDUCATIONAL SERVICE UNIT NO. 11

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SAT Referral to Special Education Consideration

Student:_____ **Referral Source:**_____
Age/Grade:_____ **Date of Meeting:**_____
Assigned Case Manager:_____ **Date of Follow-Up next Meeting:**_____
Parents:_____ **Parents Attended?** ☐ **Yes** ☐ **No**

Those in Attendance:

_____ _____
_____ _____
_____ _____

Areas of Evaluations (check those apply): ☐ *Psych* ☐ *Speech/Language* ☐ *OT* ☐ *PT*
☐ *Vision* ☐ *Audiological Evaluation* ☐ *Other:*_____

*** If vision evaluation referral, please indicate date of last vision examination by Optometrist/Opthalmologist AND ATTACH REPORT. Date:*_____

Summarize options the district considered before recommending testing:

_____
_____
_____

Summarize why these reasons were rejected:

_____
_____
_____

School District Administrator Notified of Referral ☐ ***Yes*** ☐ ***No***

Administrator Contacted and Date:
*Name:*_____ *Date:*_____ *Phone Number:*_____

Date this referral was sent to Special Education Case Manager as identified below:

_____ *Psych (Resource Teacher)*
_____ *Speech/Language (SLP)*
_____ *OT/PT/Other (Resource Teacher)*

(Please check one) ◯ ***Continue*** ◯ ***Discontinue*** ***the Intervention until MDT Determination is made.***

*** This referral for Special Education Consideration is based on SAT documentation provided. ***