



Jordan-Elbridge Central School District

Committee on Pre-School Special Education (CPSE) Referral

Child's Name: _____
Last name First name Date of Birth

Parent's Name: _____
Last name First name

Home Address: _____
Street Address City State Zip

Contact Information: _____
Email Address Phone Number

Teacher's Name (if applicable): _____
Last name First name

Referral Source for this form: _____ Parent _____ Teacher

*If this child is being referred by parent and teacher, please complete two forms and staple together

If solely teacher referral, provide the date parent was notified: _____

Reason for Referral: _____

List any Early Intervention services this child received: _____

List any CPSE services this child currently receives: _____

Indicate any known pre/post-natal complications for the child: _____

Describe the child's general health: _____

Describe the child's vision: _____

Describe the child's hearing: _____



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Is the child toilet-trained? ____Yes ____No

Is the child taking any medications? ____Yes ____No If yes, for what purpose:

From your experience, mark an X for each statement that describes the child:

Sensory

	Overly sensitive to noise
	Seeks noise, inappropriate noise making
	Enjoys watching things spin
	Mouths items frequently
	Seeks movement - spinning, bouncing, jumping
	Has difficulty sitting still, staying in seat
	Avoids being touched
	Avoids messy activities
	Demonstrates rigidity in routine
	Demonstrates repetitive behavior - turning lights on/off, zipping/unzipping, etc.
	Unaware of when face/hands need to be cleaned

Fine Motor

	Cannot use crayons or pencils with correct grip
	Cannot use scissors with correct grip
	Uses too much or too little pressure when writing
	Does not cross midline
	Switches hands frequently when using fine motor tools
	Cannot imitate horizontal/vertical/circular motions on paper

Gross Motor

	Cannot walk safely - trips, falls, or bumps into things
	Cannot run safely - trips, falls, or bumps into things
	Cannot jump in place
	Cannot navigate stairs
	Cannot toss items underhand towards a target
	Cannot throw items overhand towards a target



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Speech/Language

	Cannot follow one- or two- step directions
	Cannot speak in words
	Cannot orally express his/her wants and needs
	Cannot speak in complete sentences
	Cannot be understood when speaking to an unfamiliar listener
	Cannot name common objects
	Cannot use pronouns
	Cannot retell a story or answer questions about the story

Pre-Academic/Academic

	Cannot listen to a story from start to finish
	Cannot tell first and last name
	Cannot recognize first name
	Cannot recognize last name
	Cannot write letters or numbers
	Cannot write first name
	Cannot identify colors
	Cannot identify shapes (circle, square, triangle, rectangle)
	Cannot identify numbers to 10

Behavioral

	Exhibits frequent crying
	Exhibits frequent tantrums
	Exhibits destructiveness (breaks things out of frustration and/or anger)
	Exhibits difficulty complying with adult authority

For the reasons indicated on this referral from, I believe this child requires an evaluation to
- determine the existence of a disability and eligibility to receive CPSE services, or
- investigate the need for further services for a child who is already classified.

Print name of referring person

Title/Relationship to child

Signature of referring person

Date