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 Gender

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 |

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