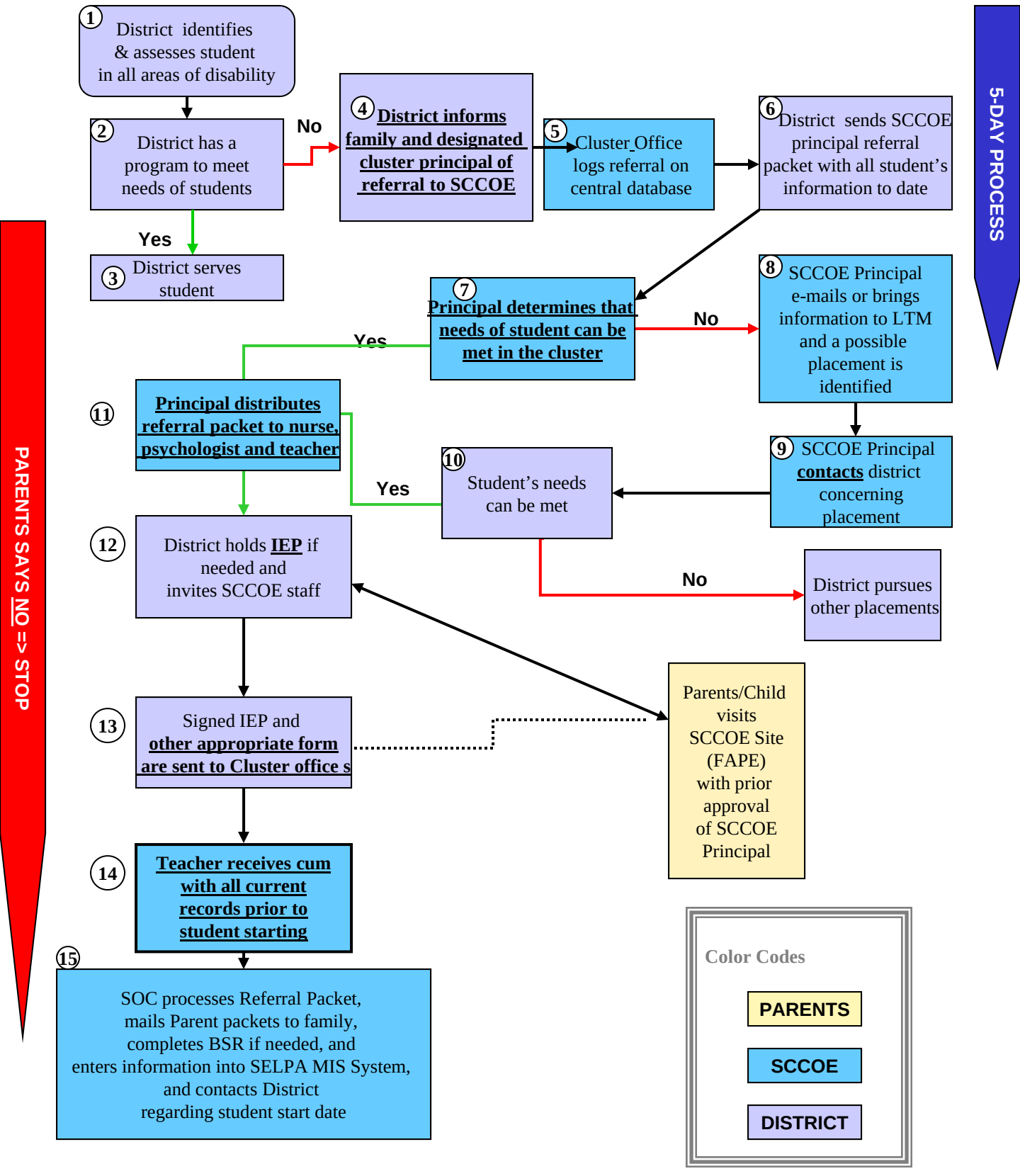
REFERRAL PROCEDURES FOR SANTA CLARA COUNTY OFFICE OF EDUCATION SPECIAL EDUCATION PROGRAMS

Student Placement Process (External)



SPECIAL EDUCATION PLACEMENT REQUEST

- **Must be used for pupils referred to COE programs**
- **May be used for pupils referred to district programs within a SELPA**

Pupil's name _____ ☐ Male ☐ Female
Address _____
_____
Birth date _____
Age _____
Birth date verified by:
____ Birth Certificate
____ Baptismal Certificate
____ Passport
____ Affidavit by:
___ Parent/Surrogate
___ Guardian
___ Custodian

Parent/Guardian/Surrogate _____
Address (if different) _____
_____
Phone _____ _____
(Home) (Work)
Primary language of pupil _____ /home _____

Referring district _____ **Referral date** _____
Contact person _____ **Phone** _____ **Title** _____
District referred to _____

Current instructional placement: ☐ Public school ☐ Non-public school ☐ Private school ☐ Not in school
☐ SDC ☐ RSP ☐ DIS ☐ Home/hospital instruction

Current school _____
Current teacher/counselor _____
Reason for referral (specific areas of concern) _____
_____
_____

Placement to be considered: ☐ SDC ☐ RSP ☐ DIS

Level of Program: ☐ **Infant/Toddler** (Birth through 2 years) ☐ **Preschool** (3 through 5 years)
☐ **K-12 grades** ☐ **Post-Secondary**

Based on the pupil's needs the following type of program is recommended: _____
_____
_____

Materials attached: (The *bold, italicized* items must be attached for COE referrals, or the referral will be returned.)

☐ ***IEP***
☐ ***Immunization record***
☐ ***Home Language Survey***
☐ ***LEP statement*** (if other than English on the *Home Language Survey*)
☐ Other _____

☐ ***Multidisciplinary team report(s)***
☐ Academic ☐ Developmental
☐ Behavioral ☐ ***Health/Develop.*** or ***Medical record***
☐ Communication ☐ ***Psycho-educational***
☐ Audiological/***hearing*** ☐ Ophthalmological/***vision***

_____ _____ _____
Signature of person submitting referral Title/Phone Date

_____ _____ _____
Signature of administrator of referring district Title/Phone Date

SELPA 011 Rev. 2/94 *WHITE-District* *YELLOW-School* *PINK-Parent* *Santa Clara County SELPAs*

Santa Clara County Office of Education

Charles Weis, Ph.D.
County Superintendent of Schools

Special Education Department

Support Services for Special Needs Students Referral Form

Date of Referral: Click here to enter a date.

Please complete the Referral Form electronically and fax to:
408-453-6643 ATTN: Shirley Robinson

COE Specialist will prepare Assessment Plan (AP) if needed. Please do not prepare ahead of time.

Student's Name: ____ DOB: ___ Age: ____

District of Residence: ____ School: _____ Room #: __ Teacher: _____

Student's Current Program (SDC, General Ed., RS, DIS services – Speech, OT, PT): _____

Contact Person: ____ Title: _____ Phone: _____ E-Mail Address: _____

_____ _____
Signature of District Administrator approving referral request Date

Print Name: ____ Title: _____ Phone: _____ Email Address: _____

Initial hours approved at: $75.00 an hour (*recommend 2 to 5 hours initially*: ____ Date: _____

(Fill out this section only when more hours are needed.)

Additional hours recommended by: ____ Hours Recommended: _____ Date: _

District Approves ___ hours. _____ _____ _____
Signature Title Date

Additional hours recommended by: ____ Hours Recommended: _____ Date: _____

District Approves ____hours. _____ _____ _____
Signature Title Date

Please check major area of referral: ___ AAC ____ AT/OI ____ Deaf/HOH ____ Dysphagia ___ Inclusion

Parent notified of referral: ___ Yes ___ No

Reason for referral: _____

Brief description of current levels (Preacademic/Academic, mobility, hearing/vision, etc.): ____

Additional comments (including any behavioral, health, and/or social emotional concerns, etc.): _____