Referral for a Student Suspected of Having a Disability

(To Be Completed by Parent or Non School Personnel)

Document Directions

HOWARD COUNTY PUBLIC SCHOOL SYSTEM

Department of Special Education and Student Services
HOWARD COUNTY PUBLIC SCHOOL SYSTEM
Ellicott City, MD 21042

Office Use Only
Date Received:

Please complete this form, print, sign, and return it to the student's school to make a referral for a suspected disability.

All of the following information is required for the Individualized Education Program (IEP) team to process a referral.

Student Name: _____ Date of Referral: ____/____/____

School: _____ Grade: _____ Date of Birth: ____/____/____

Person Making Referral:

Name: _____ Home Phone Number: _____

_____ Cell Phone Number: _____
Address Street Apt. #

_____ MD _____ Work Phone Number: _____
City State Zip

Please select the possible disability or disabilities that you suspect:

- ☐ Autism
- ☐ Deaf/Blindness
- ☐ Developmental Delay
- ☐ Emotional Disability
- ☐ Hearing Impairment
- ☐ Intellectual Disability
- ☐ Multiple Disabilities
- ☐ Orthopedic Impairment
- ☐ Other Health Impairment
- ☐ Specific Learning Disability
- ☐ Speech or Language Impairment
- ☐ Traumatic Brian Injury
- ☐ Visual Impairment

Signature: _____

Complete the following information.

1. Areas of Concern: (Check all that apply.)

- ☐ Reading
- ☐ Writing Expression
- ☐ Mathematics
- ☐ Attention/Learning Behaviors
- ☐ Other, specify
- ☐ Communication
- ☐ Memory
- ☐ Social/Emotional
- ☐ Vision
- ☐ Fine Motor (large muscle control)
- ☐ Gross Motor (small muscle control)

2. For each area of concern checked above, describe your concerns. You may use additional pages if needed.

3. The Parent Questionnaire is enclosed. ☐ Yes ☐ No

Distribution: Student Record (*Assessments and Evaluations* folder)

September 2013