ESU 7

Educational Service Unit 7

SAT Referral to Special Education Consideration

Student: _____ Referral Source: _____
Age: _____ Date of Meeting: _____
Assigned Case Manager: _____ Date of next Follow Up 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/Ophthalmologist 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

Person Contacted and Date:
Name: _____ Date: _____ Phone Number: _____

Date this referral sent to Special Education Case Manager (as identified below) Date: _____
☐ Psych (Resource Teacher) ☐ Speech/Language (SLP) ☐ OT/PT/Other (Resource Teacher)

(Please Check One) ☐ Continue ☐ Discontinue the Intervention(s) until MDT Determination is made.

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

SAVE PRINT EMAIL RESET