Clark County School District
Las Vegas, Nevada
Student Services Division

CCF-583
11/16

DATE: _____

STUDENT SERVICES REFERRAL FORM

Student Name:_____ Grade: _____ DOB: _____ ID#: _____

☐ INITIAL EVALUATION
Submit to the Principal and Multidisciplinary Team

☐ REEVALUATION
Special Education teacher to complete the following:

Date of Last Evaluation:_____

Reason for Reevaluation if other than routine: _____

Present Special Education Program: _____

Anticipated Date for Annual IEP: _____

Parent/Guardian/Surrogate:_____

Address: _____ Telephone: _____

Primary Language of Child: _____ Location: _____

Teacher(s):_____ Date of Referral: _____

Identify specific referral questions to be answered by the Multidisciplinary Team regarding this student **(Must be completed)**:

Identify previous educational interventions used with the student **(Identify interventions and outcomes)**:

Other Factors Affecting Performance:

REFERRAL SOURCE: _____ NAME _____ TITLE

REFERRAL ENTERED BY: _____ NAME _____ TITLE

REFERRAL OUTCOME

☐ Proceed with alternative intervention strategies. Team completes appropriate documentation (e.g., SIP, Section 504, other). Consider whether follow-up notice to the parent is appropriate or required.

☐ Proceed with evaluation or reevaluation. Provide the written notice to the parent (CCF-563) and obtain written consent (CCF-555), as needed.

☐ No further action needed. Team completes appropriate documentation. Consider whether follow-up notice to the parent is appropriate or required.

Distribution: Original - Confidential Folder 1st Copy - Parent/Guardian/Adult Student 2nd Copy - Special Education Teacher/School

CCSD CLARK COUNTY SCHOOL DISTRICT