



Orange County Department of Education
Special Education Services - Referral Facesheet

District of Residence \_\_\_\_\_

Student Name \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone \_\_\_\_\_ DOB \_\_\_\_\_

Student Lives [ ] at Home [ ] in Group Home Date of Initial Referral to District/SELPA \_\_\_\_\_

Student Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent Name \_\_\_\_\_ Work Phone \_\_\_\_\_ [ ] Parent Interpreter Needed

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Please check all the boxes that apply:

- [ ] Ambulatory [ ] Non-Ambulatory [ ] Bus Assistant
[ ] Safety Vest - Size (color): \_\_\_\_\_ [ ] Wheelchair [ ] Car Seat [ ] 1:1 Classroom Assistant

SPECIAL SCHOOLS PROGRAMS FOR CONSIDERATION (Check one):

- [ ] Severely Disabled (medically fragile, moderate to severe disabilities) [ ] Language/Behavior/Autism Spectrum
[ ] Deaf/Hard-of-Hearing Program (TC/Oral) [ ] Emotionally Disturbed
[ ] Community Day School
[ ] Dual Diagnosis Class

PLACEMENT OPTIONS PREVIOUSLY CONSIDERED:

- [ ] General Education Program [ ] Other Designated Instructional Services
[ ] Small Group Instruction in General Education [ ] Other \_\_\_\_\_
[ ] Small Group Instruction outside General Education

The full continuum of placement options has been considered by the district/SELPA. The options indicated as considered cannot be modified to meet the identified needs of this pupil.

Signature \_\_\_\_\_

District/SELPA Representative

Please include the following documents and information with this referral:

Date Completed

- 1. Parental Authorization for exchange of information with OCDE Special Schools Program \_\_\_\_\_
2. District/SELPA Assessment Plan & Documentation of Parents Informed Consent \_\_\_\_\_
3. Verification that parents have been informed of their rights \_\_\_\_\_
4. Home Language Survey \_\_\_\_\_
5. Current Assessment Reports
a. Medical Reports (as appropriate)
(1) Physician's Report \_\_\_\_\_
(2) California School Immunization Record/Waiver \_\_\_\_\_
(3) Vision and Hearing Screening \_\_\_\_\_
(4) Audiological Evaluation \_\_\_\_\_
b. Multidisciplinary or Individual Reports including:
(1) Developmental and Health History \_\_\_\_\_
(2) Psychological Report (please include behavioral description/Hughes Plan) \_\_\_\_\_
(3) Speech and Language Report (for EL students, include CELDT or ALPI results) \_\_\_\_\_
(4) A statement of why referral to the OCDE Special Schools Program has been determined appropriate \_\_\_\_\_
6. Present Levels of Performance (complete section on OCDE's IEP forms and include the current IEP, if available). \_\_\_\_\_
7. STAR Test Scores (if applicable) \_\_\_\_\_
8. Transition Plan (for students 16 years old and older) \_\_\_\_\_
9. Verification of Parent Visitation to Special Schools Program(s) \_\_\_\_\_ Site(s) \_\_\_\_\_
10. History of Complaints, Resolution Sessions, ADR or Agreements (see additional page for comments) \_\_\_\_\_

Please submit completed referral packet to:

- A. Orange County Department of Education Special Schools Principal at the appropriate site
- or -
B. Special Education Services Administration Office, 200 Kalmus Drive, Costa Mesa, CA 92626

Name of District/SELPA personnel to contact concerning this referral \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date \_\_\_\_\_



**ORANGE COUNTY DEPARTMENT OF EDUCATION  
SPECIAL EDUCATION SERVICES**

**REFERRAL PROCEDURES**

- A. The referring district/SELPA should contact the OCDE Special Schools principal to discuss a possible referral. If the referral seems appropriate, the referring district/SELPA will complete the referral packet which includes:
1. Parental Authorization for exchange of information with OCDE Special Schools Program
  2. District/SELPA Assessment Plan and Documentation of Parent's Informed Consent to the Assessment Plan
  3. Verification that parents have been informed of their rights
  4. Home Language Survey
  5. Current Assessment Reports
    - a. Medical Reports (as appropriate)
      - (1) Physician's Report
      - (2) California School Immunization Record (or physician waiver)
      - (3) Vision and Hearing Screening results
      - (4) Audiological Evaluation
    - b. Multidisciplinary or individual reports including:
      - (1) Developmental and Health History
      - (2) Psychological Report (please include behavioral description). For students who demonstrate assaultive behavior, include a description of the nature and frequency of the behavior and/or a copy of the student's behavior support or Hughes Plan.
      - (3) Speech and Language Report (for EL students, include CELDT or ALPI results)
      - (4) A statement of why a referral to the Special Schools Program has been determined appropriate
  6. Present Levels of Performance (complete section on OCDE's IEP forms and include the current IEP, if available)
  7. STAR Test Scores (if applicable)
  8. Transition Plan (for students 16 years old and older)
  9. Verification of Parent Visitation
  10. History of Complaints, Resolution Sessions, ADR or Agreements (Supplemental Information Form to be completed)
- B. Send the completed referral packet to the appropriate OCDE principal.
- C. If the parent has not already had the opportunity to see the OCDE Special Schools site, a visitation should be arranged and, if possible, the child should also attend. The referring district/SELPA shall provide an interpreter, when needed, for parents who are not proficient in English.
- D. After receipt of the referral packet and the parent visitation, the OCDE principal will contact the district/SELPA to facilitate the planning of the IEP meeting.
- E. The Special Schools principal and/or other Special Schools staff will attend the IEP team meeting to be held by the referring District/SELPA. The District/SELPA may request that the Special Schools staff conduct the IEP team meeting. The District/SELPA will send a representative to this meeting.
- F. At the IEP team meeting, the IEP will be mutually developed by district staff, OCDE staff, and parent on OCDE IEP forms. The District/SELPA may wish to simultaneously develop the IEP on their District/SELPA IEP forms.
- G. The district will be contacted, at least annually, by the principal for an IEP meeting in order to review the student's progress, develop a new IEP and determine placement.

*Should a District/SELPA need clarification as to the appropriate Special Schools program for referral, the Special Education Services administration office may be contacted at (714) 966-4133.*





**ORANGE COUNTY DEPARTMENT OF EDUCATION  
SPECIAL EDUCATION SERVICES  
IEP Present Levels**

Student Name: \_\_\_\_\_ Date \_\_\_\_\_

**PRE-ACADEMIC/ACADEMIC/COGNITIVE/FUNCTIONAL SKILLS**

Skills related to academics that are functional in terms of daily living activities

(Examples: fine motor, math, computer usage, reading/symbol identification)

*Goals written in this area may be aligned with one or more of the following standards-based core curriculum areas:*

English/Language Arts, Math, History/Social Science, Science

**PRESENT LEVELS OF PERFORMANCE:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COMMUNICATION DEVELOPMENT**

Skills related to the ability to comprehend and express information in a variety of ways

(Examples: expressive/receptive language, verbal, nonverbal, gestural, augmented communication systems)

*Goals written in this area may be aligned with one or more of the following standards-based core curriculum areas:*

English/Language Arts, Visual and Performing Arts, Health

**PRESENT LEVELS OF PERFORMANCE:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MOTOR DEVELOPMENT**

Skills related to fine and gross motor development, increasing independence and physical access to a variety of environments

(Examples: finger dexterity, handwriting, ambulation, strength, balance, coordination, wheelchair use)

*Goals written in this area may be aligned with one or more of the following standards-based core curriculum areas:*

Visual and Performing Arts, Physical Education

**PRESENT LEVELS OF PERFORMANCE:** (Fine Motor) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Gross Motor) \_\_\_\_\_



**ORANGE COUNTY DEPARTMENT OF EDUCATION  
SPECIAL EDUCATION SERVICES  
IEP Present Levels**

**SOCIAL/EMOTIONAL**

Skills related to social exchanges, playing with others, making choices, regulating behavior  
(Examples: coping with demands, controlling impulses)

*Goals written in this area may be aligned with one or more of the following standards-based core curriculum areas:  
History/Social Science, Visual and Performing Arts, Health, Physical Education*

**PRESENT LEVELS OF PERFORMANCE:** \_\_\_\_\_

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**SELF HELP**

Skills related to functioning within a home and the maintenance of one's health  
(Examples: toileting, eating, dressing, hygiene, grooming)

*Goals written in this area may be aligned with one the following standards-based core curriculum area: Health*

**PRESENT LEVELS OF PERFORMANCE:** \_\_\_\_\_

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**VOCATIONAL**

Skills related to specific work tasks  
(Examples: task completion, self-management, specific job skills)

*Goals written in this area may be aligned with one or more of the following standards-based core curriculum areas:  
English/Language Arts, Math, History/Social Science, Science, Visual and Performing Arts, Health, Physical Education*

**PRESENT LEVELS OF PERFORMANCE:** \_\_\_\_\_

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**ORANGE COUNTY DEPARTMENT OF EDUCATION  
SPECIAL EDUCATION SERVICES  
PARENT/PHYSICIAN LETTER**

Dear Parent and Examining Physician:

\_\_\_\_\_ has been referred for possible placement in the \_\_\_\_\_ Program. A requirement for admission into the program is the completion of several forms by the parent and the child's physician.

A PHYSICIAN'S REPORT is required for admittance into the program. This report includes immunizations, height, weight, review of systems, etc. The physician can assist in proper special school placement by describing any disabilities the child has requiring special attention by school personnel.

IMMUNIZATIONS need to be verified. If a physician is being seen who did not immunize the child, remember to bring your records to the physician's office. The physician can then verify and update the records and complete the immunization section of the Physician's Report form. If the child's immunizations are not updated in accordance with the new state laws, he/she will be admitted conditionally into the program. This means the child will have only ten days to begin the immunizations or he/she will be excluded from school.

MEDICATION FORMS – Parents are requested to inform the school yearly if their child is taking continuing medications at home. Parents are encouraged to try and work out a medication schedule so that their child does not need to take medicine at school. If this will not be feasible, have your physician complete the Physician's Request for Administration of Medication by School Personnel.

CALIFORNIA CHILDREN SERVICES OF ORANGE COUNTY offers physical and occupational therapy to those students who qualify for services. A prescription from the physician for physical therapy and/or occupational therapy will initiate the CCS referral.

LEGALLY BLIND STATEMENT – If the child's vision with glasses is still impaired he/she may be eligible for special teaching materials. A statement from the physician stating the child is legally blind is required.

If you have any questions regarding the forms and/or the referral process, please contact the Chief of Special Education Services at (714) 966-4130.

Sincerely,

Dennis Roberson  
Chief, Special Education Services



**ORANGE COUNTY DEPARTMENT OF EDUCATION  
SPECIAL EDUCATION SERVICES  
PARENT/PHYSICIAN LETTER**

Estimado Padre de Familia y Médico:

\_\_\_\_\_ ha sido referido para admisión en el programa .  
\_\_\_\_\_. Uno de los requisitos para que su niño(a) sea admitido al programa es que Ud. Y el médico de su niño(a) completen varias formas. Lea esta carta cuidadosamente pues así se evitará el tener que ir al doctor una segunda vez.

Para que el niño sea admitido al programa es necesario un INFORME MEDICO. Este informe deberá incluir el historial de vacunas, estatura, peso, los resultados del examen físico general de su hijo(a), etc. El medico ayudará a que su niño(a) sea colocado en el programa de educación especial apropiado dándonos información sobre cualquier incapacidad de su hijo que requiera atención especial por parte del personal escolar.

Las PRUEBAS de VACUNAS deben ser verificadas. Si el médico que revise a su niño(a) para este informe no es quien le administró las vacunas, es necesario que Ud. entregue a este médico el record de vacunas de su hijo(a). Esto ayudará a que el médico verifique y ponga al día los records y también a que complete la sección sobre vacunas del informe médico. Si las vacunas del niño(a) no están al día como lo requieren las nuevas leyes del estado, él o ella serán admitidos al programa en forma condicional. Esto quiere decir que Ud. sólo tiene diez días para que su niño(a) se ponga al día con sus vacunas. De ocurrir lo contrario, él o ella serán sacados del programa escolar.

PERMISO PARA EL SUMINISTRO DE MEDICINAS – Es necesario que los padres del niño(a) informen a la escuela periódicamente si él o ella están tomando medicinas en el hogar. Es preferible que los niños tomen sus medicinas en casa. Si esto no fuera posible, haga que el médico llene la forma “Permiso Médico Para el Suministro de Medicamentos por Personal Escolar.”

La OFICINA de SERVICIOS PARA Niños de CALIFORNIA del CONDADO de ORANGE ofrece terapia física y ocupacional a aquellos estudiantes que califican para este servicio. Si su niño(a) requiere de estos servicios, el médico debe indicarlo en forma escrita. La carta del médico nos servirá para iniciar el proceso de referencia de su hijo(a) con esta agencia.

DECLARACION DE CEGUERA TOTAL – Si su niño(a) tiene problemas de visión aún usando anteojos, él o ella pueden calificar para materiales de enseñanza especiales. El único requisito es una declaración escrita por el médico diciendo que el niño(a) está legalmente ciego(a).

Si Ud. tiene alguna pregunta en relación a estas formas o con el proceso de referencia, comuníquese con el Chief de Educación Especial al teléfono (714) 966-4130.

Attentamente,

Dennis Roberson  
Chief, Special Education Services



**ORANGE COUNTY DEPARTMENT OF EDUCATION  
SPECIAL EDUCATION SERVICES  
PHYSICIAN'S REPORT**

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

History of Present Problem \_\_\_\_\_

**IMMUNIZATIONS (Date)**

POLIO (1<sup>st</sup>) \_\_\_\_\_ (2<sup>nd</sup>) \_\_\_\_\_ (3<sup>rd</sup>) \_\_\_\_\_ Booster # \_\_\_\_\_

DPT (1<sup>st</sup>) \_\_\_\_\_ (2<sup>nd</sup>) \_\_\_\_\_ (3<sup>rd</sup>) \_\_\_\_\_ (4<sup>th</sup>) \_\_\_\_\_ Booster # \_\_\_\_\_

MMR (1<sup>st</sup>) \_\_\_\_\_ (2<sup>nd</sup>) \_\_\_\_\_ TB Mantoux Skin Test (Results in mm)

(Polio, DPT and MMR are required by California State Law)

HIB (1<sup>st</sup>) \_\_\_\_\_ (2<sup>nd</sup>) \_\_\_\_\_ (3<sup>rd</sup>) \_\_\_\_\_ Varicella \_\_\_\_\_

Hepatitis B (1<sup>st</sup>) \_\_\_\_\_ (2<sup>nd</sup>) \_\_\_\_\_ (3<sup>rd</sup>) \_\_\_\_\_

What hospitals, clinics or other agencies have had contact with pupil?

(1) Name \_\_\_\_\_ Case # \_\_\_\_\_

(2) Name \_\_\_\_\_ Case # \_\_\_\_\_

**PHYSICAL EXAMINATION**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**EYE, EAR, NOSE and THROAT:** (Including appearance of head and face. If a hearing or vision test was done, report results) \_\_\_\_\_

**LUNGS and RESPIRATORY SYSTEM**

**HEART**

**ABDOMEN**

**NEUROMUSCULAR** (Incoordination, abnormal reflexes, spasticity in extremities, sensory deficits, muscle strength, etc.) \_\_\_\_\_

**FUNCTIONAL LEVEL** (Sit, crawl, stand, walk, bowel and bladder control, etc.) \_\_\_\_\_

**PERTINENT LABORATORY DATA** (CBC, URINALYSIS, EEG, X-RAY, ETC.) \_\_\_\_\_



**DIAGNOSIS** (including impression of seizure disorder, cerebral palsy, mental retardation, speech impairment, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RECOMMENDATIONS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL THERAPY** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EQUIPMENT NEEDED** (wheelchair, crutches, braces, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REST PERIODS DURING SCHOOL DAY** ( if required, note duration and frequency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPECIFIC PHYSICAL RESTRICTIONS** (sitting, standing, walking, running, stair steps, lifting, common playground equipment, physical contact games, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WATER ORIENTATION** (School sponsored program) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER** (Further medical evaluation, speech therapy, special behavioral concerns, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date of Next Examination

\_\_\_\_\_  
Address Phone

\_\_\_\_\_  
City Zip Code