

Capistrano Unified School District
San Juan Capistrano, California

Referral for Special Education Assessment

Student's Name _____ Date of Birth _____
Last First MI

Parents Name _____ Phone _____
Last First MI

Address _____
Number and Street City State Zip Code

After thorough review by the Student Study Team, it has now recommended that the above named student be assessed to determine if special education and/or related services are appropriate to his/her educational needs.

The following are suspected areas of disability.

- Academic skills
- Language and/or speech skills
- Sensory motor skills
- Intellectual/cognitive skills
- Social and emotional behavior
- Health and/or physical concerns
- Other _____

A vision and hearing screening must have been completed, within the past 12 months of this referral.

An assessment plan must be developed within 15 days.

Date of Referral

Student Study Team Chairperson