

Capistrano Unified School District
San Juan Capistrano, California

REFERRAL TO SPECIAL EDUCATION SHARED CLASSES

Student's Name: _____ Birth Date: _____ Sex: _____
Parent/Guardian Name: _____ Phone: (H) _____ (W) _____
Student's Address: _____ City: _____ Zip Code: _____
District of Residence: _____ School of Attendance: _____
Current Special Ed. Placement: _____
Current Special Ed. Related Services: _____
Referral Packet Completed by: _____ Date Referral Initiated: _____

PLACEMENT AND SERVICE OPTIONS PREVIOUSLY IMPLEMENTED:

- | | |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Special Day Class Placement | <input type="checkbox"/> DIS Counseling |
| <input type="checkbox"/> OCMH Referral | <input type="checkbox"/> Referral to Behavior Intervention Case Manager |
| <input type="checkbox"/> Increasing Instructional and/or Behavioral Support | <input type="checkbox"/> Other: _____ |

The options implemented cannot be modified to meet the identified needs of this student.

Signature of Site Administrator: _____ Date: _____

Signature of Psychologist: _____ Date: _____

THE FOLLOWING INFORMATION SHOULD BE INCLUDED FOR EACH REFERRAL PACKET:

- | | Date Completed |
|---------------------------------------------------------------------------------------------|-----------------------|
| 1. Current IEP | _____ |
| 2. <i>Part IV Behavior Management Plan or Hughes Positive Behavior Intervention Plan</i> | _____ |
| 3. Multidisciplinary or Individual Reports Including: | _____ |
| * Development and Health History | _____ |
| * Psychological Report (include behavioral assessment) | _____ |
| * Language, Speech, and Hearing Report | _____ |
| * A written explanation of why referral to the Shared class has been determined appropriate | _____ |
| 4. Medical Reports | _____ |
| * Physician's Report (if applicable) | _____ |
| * California School immunization Report | _____ |
| * Vision and Hearing Screening Report (if a problem is suspected) | _____ |
| 5. Verification of Parent Visitation to Shared class | _____ |

SUBMIT COMPLETED REFERRAL PACKET TO:

South orange County SELPA, 25631 Peter A. Hartman Way, Mission Viejo, CA 92691
949-586-3212 * (FAX) 949-454-1711

Name of person to contact concerning this referral: _____