WARREN COUNTY SCHOOLS
Exceptional Children Programs

REFERRAL FOR TESTING
INITIAL

School: _____

Name (Please Print): _____

SIMS #: _____

Teacher: _____

Date of Birth: _____ Date Referral Received by School: _____ Grade: _____

Date Passed Hearing Screening: _____

Date Passed Vision Screening: _____

Student is being referred for *(Please check all that apply):*

❑ Academic ❑ Behavior ❑ OHI

Gender: _____ Race: _____

☒ Needed Assessment Areas:

☐ Vision ☐ Hearing/Audiological ☐ Speech/Language
☐ Intellectual Functioning ☐ Physical/Motor ☐ Adaptive Behavior Functioning
☐ Occupational Therapy ☐ Physical Therapy ☐ Behavioral/Emotional Functioning
☐ Academic/Pre-Academic/Developmental Achievement
☐ Other (please specify):_____

COMMENTS:

This form must be filled out ***completely* and given to the Exceptional Children Director with a copy of the Referral Documents (RE 1, RE 2, DEC 1, and DEC 2) in order to begin the assessment process.**