

**CONFIDENTIAL INFORMATION**  
(for professional use only)

**CHATTAHOOCHEE-FLINT RESA**  
**Psychological Services**  
**REFERRAL FOR PSYCHOLOGICAL EVALUATION**

*(Please check one)*

- Referral for Initial Evaluation
- Referral for Evaluation for Students Served Only in Speech/Language
- Out of State Transfer Re-evaluations

\_\_\_\_\_  
Date Received by RESA

\_\_\_\_\_  
Placement Meeting Due Date  
(To Be Completed by RESA)

\_\_\_\_\_  
Date Parent Consent Received

**I. Identifying Information**

Student Name \_\_\_\_\_ Parents Name \_\_\_\_\_  
 School System \_\_\_\_\_ Address \_\_\_\_\_  
 School \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ Grades Repeated \_\_\_\_\_

**II. Referral Information**

**A. For what reason is the Student Support Team referring this student for psychological evaluation? If the student is being referred for learning problems, specifically describe academic achievement in all his/her subject areas.** \_\_\_\_\_

**If the student is being referred for emotional/behavioral concerns, specifically describe these problems and explain how they adversely affect the student's academic achievement.** \_\_\_\_\_

Does the student receive other services? S/L \_\_\_\_\_ PT \_\_\_\_\_ OT \_\_\_\_\_ Counseling \_\_\_\_\_ (School \_\_\_\_\_ Other \_\_\_\_\_)  
Public/Private Agency Involvement \_\_\_\_\_ If yes, specify \_\_\_\_\_

**B. Results of Achievement/Cognitive screening: (This may be obtained from statewide testing in the cumulative or instructional folder or from individual screening. Testing must have been completed within one year of the date this referral is received by RESA.)**

Academic Achievement Test: \_\_\_\_\_ Date: \_\_\_\_\_  

<u>Subject</u>	<u>Standard Score</u> (If individual achievement test is given)	<u>Percentile or Grade Equivalent</u> (If group achievement test is given)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Intelligence/Cognitive Test: \_\_\_\_\_ Date \_\_\_\_\_ IQ \_\_\_\_\_

**C. Medical Information:**

Does this student have medical problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe the problem \_\_\_\_\_

Including medication regularly administered at home \_\_\_\_\_ AND/OR at school \_\_\_\_\_

Does this student have special needs that might require accommodations during test? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain briefly \_\_\_\_\_

D. Routine auditory and visual screening was completed on \_\_\_\_\_ (Date). Does this student wear glasses (Yes \_\_\_ No \_\_\_), hearing aids (Yes \_\_\_ No \_\_\_)?

**3. Attachments to Referral (Required):**

- 1. Parent Consent for Evaluation.
- 2. Auditory and visual screening within one year. (If failure of vision and/or hearing occurs, follow-up evaluation and correction shall be included with this referral, If a vision or hearing problem is determined to be uncorrectable, documentation by an appropriate medical professional, including any modifications needed in the evaluation process, should be attached to this referral.)

**4. Attachments to Referral (Beneficial):**

- 1. Attach work samples that indicate the student's difficulties in the identified academic problem areas.
- 2. If available, a copy of the cumulative folder page which shows group test scores and school grades.
- 3. A copy of a learning disabilities checklist (i.e., LDES) that indicates the nature of learning difficulties.
- 4. A completed adaptive behavioral rating scale (i.e., age appropriate Vineland) if this is an area of concern.
- 5. A completed emotional/behavioral rating scale and/or teacher's behavior logs if this is an area of concern.

(Note: Section G is not applicable to pre-school students.)

- 1. Have you included a referral to the Student Support Team? Yes \_\_\_
- 2. Have you included specific alternative instructional interventions in your SST report and the results? Yes \_\_\_
- 3. Have you included the SST minutes? Yes \_\_\_
- 4. Have you made your final recommendation clear? Yes \_\_\_

**MAKE SURE ALL OF THE ABOVE ITEMS ARE INCLUDED!  
INCOMPLETE REFERRALS WILL BE RETURNED**

Signatures:

Teacher _____	Date _____
Principal _____	Date _____
Special Education Director _____	Date _____

**TURN TO: Chattahoochee-Flint RESA  
Pupil Services Department  
PO Box 1150  
Ellaville, GA 31806**

(Revised 07/2007)