

Date Completed: _____

Testing Date: _____

SUNRISE PRESCHOOL: 4-YEAR-OLD SPECIAL EDUCATION REFERRAL FORM

This information will be used as part of your student's evaluation and will be kept confidential.

CHILD AND FAMILY INFORMATION

Child's Name: _____ DOB: _____ Male Female
(First) (Middle) (Last)

Parent/Guardian Name: _____ Phone Number: _____ Relation: _____

Parent/Contact Name: _____ Phone Number: _____ Relation: _____

Home Address: _____
(Street Number) (City) (Zip)

Parent Email: _____

HOME LANGUAGE

Primary Language: _____ *Second Language: _____

Interpreter needed for parent meetings? Yes No

*If a language other than English is spoken in the home, please complete the Culturally & Linguistically Diverse Form

DAYCARE / PRESCHOOL EXPERIENCE

Does your child spend any time in a daycare or preschool program? (Head Start, Private Preschool, or Daycare) Yes No

Name of Daycare or Preschool: _____

Days and Hours Attending: _____

GROUP / CLASSROOM FUNCTIONING

In a group or class, does your child: (If no group or classroom experience, mark N/A)

Remain seated when appropriate? Yes No N/A

Follow the routine and transition between activities? Yes No N/A

Pay attention to activities and tasks for 5-10 minutes? Yes No N/A

Participate in activities? Yes No N/A

MEDICAL HISTORY

Does your child receive any services / therapies from another provider (e.g. OT, PT, Speech, ABA)? Yes No

If yes, please list: _____

Does your child have a medical diagnosis? Yes No

If yes, please list: _____

Does your child use any type of medical equipment (e.g. Wheelchair, Oxygen, G-tube)? Yes No

If yes, please list: _____

Has your child ever had any significant injuries or hospitalizations/surgical procedures? Yes No

If yes, please list: _____

Does your child have any allergies? Yes No

If yes, please list: _____

Does your child have any relatives who have known delays or disabilities? Yes No

If yes, please list: _____

VISION / HEARING

Are you concerned about your child's vision? Yes No If yes, please explain: _____

Are you concerned about your child's hearing? Yes No If yes, please explain: _____

ARTICULATION / STUTTERING

Are you concerned about your child's speech being understood? Yes No Not yet speaking (If No, proceed to communication section)

If yes, please explain: _____

What are your concerns regarding your child's speech development? (Mark all that apply)

Removing Sounds Substitutes sounds *Stuttering concerns Speaking quietly Other: _____

**Stuttering / fluency: unusual pauses, frequent repetitions of sounds or words, or drawing out certain sounds*

Are you concerned with your child's ability to produce any earlier-developing speech sounds? (/p, b, t, d, k, g, m, n, f, h, w/)?

If yes, please list: _____

How well is your child's speech understood by the primary caregiver?

0-25% of the time 25-50% of the time 50-75% of the time 75-100% of the time

How well is your child's speech understood by familiar people (such as other family members)?

0-25% of the time 25-50% of the time 50-75% of the time 75-100% of the time

How well is your child's speech understood by unfamiliar people (such as neighbors, peers, etc)?

0-25% of the time 25-50% of the time 50-75% of the time 75-100% of the time

COMMUNICATION

Are you concerned about your child's language / communication development? Yes No (If No, proceed to Social section)

If yes, please explain: _____

How does your child *usually* communicate information, wants, and needs? (Mark all that apply)

None Gestures and Pointing Babbling Word Approximations Sign Language Words

How frequently does your child use:

Single Words (e.g. "More"): Never Sometimes Often Almost Always

2 Words Together (e.g. "More cookies"): Never Sometimes Often Almost Always

3-4 Words Together (e.g. "I want more cookies"): Never Sometimes Often Almost Always

5+ Words Together (e.g. "Can I have more cookies please?"): Never Sometimes Often Almost Always

Does your child answer simple questions (who, what, where, when)? Yes No

Does your child *understand* simple directions?

1-part directions (e.g. "go get your shoes")? Yes No

2-part directions (e.g. "pick up your jacket and put it away")? Yes No

Does your child understand and use nouns/objects & verbs/actions? Yes No

SOCIAL

Are you concerned about your child's social development? Yes No (If No, proceed to Behavior section)

If yes, please explain: _____

How often does your child play with other children? daily ___ time(s) weekly monthly rarely

In what settings does your child typically interact with other children? Home Playgroups Church Playgrounds
Other: _____

Is your child able to:

Initiate play and social interactions with adults or other children? Yes No

Interactively play with other children (e.g. build things together)? Yes No

Share and take turns with others appropriately for his/her age? Yes No

Put away toys or items when asked? Yes No

Give his/her personal information? (Mark all that apply) First Name Last Name Age

Does your child have difficulty engaging with others (making eye contact, playing, etc.): Yes No

Has anybody brought up concerns of Autism for your child? Yes No

If yes, please explain: _____

BEHAVIOR

Are you concerned about your child's emotional or behavioral development? Yes No (If No, proceed to Adaptive section)

If yes, please explain: _____

Does your child:

Calm herself /himself when upset and label and understand emotions? Yes No

Demonstrate extreme refusal behavior with any adults? Yes No

Demonstrate extreme aggressive behavior toward others? Yes No

Engage in extreme behavior or tantrums? Yes No

Frequency of behavior: _____

Duration of behavior: _____

What does your child do when upset or engaging in extreme behavior?: (Mark all that apply)

Scream or Cry Hit Kick Bite Scratch Throw items Refuse Drop to the ground

Yell / Argue Other: _____

ADAPTIVE

Are you concerned about your child's adaptive (self-help / independence) skills? Yes No (If No, proceed to Motor section)

If yes, please explain: _____

Does your child:

Put away toys or items when asked? Yes No

Make requests and ask for help when needed? Yes No

Participate in self-care activities appropriately (e.g. brush teeth, get dressed)? Yes No

Follow home routines and transition between activities? Yes No

Adjust to changes in routine? Yes No

MOTOR

Children ages 3 and 4 should be able to:

- Gross Motor: run, jump, throw, kick, walk up and down stairs, and play on playground equipment
- Fine Motor: pick up small items, use crayons/markers to scribble, attempt puzzles

Do you have concerns with motor development? Yes No *(If No, proceed to Cognitive section)*

If yes, please explain: _____

COGNITIVE / PRE-ACADEMIC

Are you concerned about your child's pre-academic skills or ability to learn new things? Yes No *(If No, proceed to next section)*

If yes, please explain: _____

ATTENTION / MEMORY

Does your child:

- Pay attention to tasks and activities for 10-30 min? Yes No
- Pay attention to an adult-directed activity (book, game, etc.,) for 8-10 min? Yes No
- Remember parts of a story or recall recent events? Yes No

PRE-ACADEMIC SKILLS

Is your child able to:

- Match and sort items and pictures? Yes No No Opportunity
- Count? To what number? _____ Yes No No Opportunity
- Identify some colors (point to or name)? _____ Yes No No Opportunity
- Identify some shapes (point to or name)? _____ Yes No No Opportunity
- Identify some numbers (point to or name)? _____ Yes No No Opportunity
- Identify some letters (point to or name)? _____ Yes No No Opportunity

ADDITIONAL INFORMATION

Tell us a little more about your child (temperament, likes, dislikes, etc.):

If there is any other information you feel would be helpful for us to know about your child or family that has not yet been addressed, please use this space:

Signature: _____

Date: _____