

# COOPERATIVE ASSOCIATION for SPECIAL EDUCATION

## Itinerant Services Office

1104 N Main Street  
Lombard IL 60148-1362

Voice or TTY (630) 629-2600  
FAX (630) 629-2601

Jim T. Nelson  
Executive Director

---

2011-2012

Dear Educator:

The Cooperative Association for Special Education (C.A.S.E.) is pleased to provide you the attached Low Incidence Referral Packet for hearing, vision, and physical itinerant services. All enclosed forms may be duplicated.

Referrals to Low Incidence Itinerant Services, as part of the full and comprehensive case study, for individuals 3 to 22 years, are made by the multi-disciplinary team when the student is being considered for special education services or at any time when an educational disability in the areas of hearing, vision, or physical impairment is suspected. The referral process should follow district procedures in accordance with state and federal statutes and regulations.

Please mail a copy of the completed itinerant referral to:

Mary M. Furbush  
C.A.S.E. Itinerant Services  
1104 N. Main Street  
Lombard, IL 60148

When all referral materials are received, the student will be evaluated by a member of the C.A.S.E. Itinerant Services diagnostic staff in the low incidence domain requested. There will be a diagnostic evaluation charge for each individual evaluation. The school district will receive a copy of the functional report and be billed for the service upon completion of the evaluation.

C.A.S.E. staff members are available if needed to in-service school districts regarding the use of these forms. If you have any questions regarding the enclosed information or children considered for evaluation, please feel free to contact us.

Respectfully,



Mary M. Furbush, Ed.D.  
Itinerant Services Administrator

# COOPERATIVE ASSOCIATION for SPECIAL EDUCATION

## Itinerant Services Office

1104 N Main Street  
Lombard IL 60148-1362

Voice or TTY (630) 629-2600  
FAX (630) 629-2601

Jim T. Nelson  
Executive Director

---

## Checklist for Low-Incidence Referrals

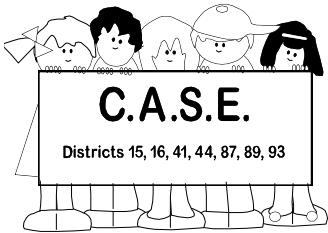
Please attach this needed documentation:

- Domain sheet and parent/guardian consent for evaluation**
- Educational screening form completed by teacher(s)**
  - Completed by classroom teacher, not SLP/nurse/administrator
  - If not attending school, form filled out by someone who has seen the child: Therapist for drop-in services, private pre-school teacher, etc.
- Appropriate medical information (current ocular for vision, audiological for hearing, medical for physical referral)**
  - School Screening are not accepted for "Audiological" or "Ocular"
  - SASED Audiological Evaluation is an option for hearing.
- Appropriate educational information (i.e. IEP, 504 Plan)**
  - Include student's IEP even if eligibility is not a low incidence category
- Appropriate administrative signatures (see below)**
  - School Referral Source
  - District Special Education Director
  - Joint Agreement Director's Director
- Class schedule (Jr. High and High School)**

**All of the above materials can be mailed or faxed to:**

Mary M. Furbush  
C.A.S.E. Itinerant Services Office  
1104 N. Main Street  
Lombard, IL 60148  
Fax: 630-629-2601

It is the mission of CASE to collaborate as educational advocates for children with special needs in order to provide appropriate and high quality educational programs and services.



**Excellence Together**

# COOPERATIVE ASSOCIATION for SPECIAL EDUCATION

## Itinerant Services Office

1104 N Main Street  
Lombard IL 60148-1362

Voice or TTY (630) 629-2600  
FAX (630) 629-2601

Jim T. Nelson  
Executive Director

### REFERRAL FOR SERVICES

**Referral Information:**

Student Name \_\_\_\_\_ Gender: Male/Female Date of Birth \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent(s)/Guardian(s) \_\_\_\_\_ Work/Cell phone (\_\_\_\_) \_\_\_\_\_

Joint Agreement \_\_\_\_\_ Attending School \_\_\_\_\_ District \_\_\_\_\_

Teacher's Name \_\_\_\_\_ Grade \_\_\_\_\_ Attends: AM only, PM only, Full day

School Nurse \_\_\_\_\_ School Phone(\_\_\_\_) \_\_\_\_\_

Specific concerns that led to this referral: \_\_\_\_\_

**Type of evaluation requested:**

\_\_\_\_ Vision Functioning Assessment

*Upon receipt of the referral a Functional Vision Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.*

Please note: An Orientation and Mobility Assessment can be requested if the student is currently receiving vision itinerant services or at the same time a request is made for a Vision Functioning Assessment.

\_\_\_\_ Physical Functioning Assessment

*Upon receipt of the referral a Physical Functional observation and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.*

\_\_\_\_ Hearing Functioning Assessment

*Upon receipt of the referral a Functional Hearing Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.*

Please note: Audiological evaluations are completed through SASSED DuPage West Cook. If you wish to request an audiological evaluation you will need to complete the referral to SASSED Dupage West Cook. Please contact SASSED DuPage West Cook directly at (630) 778-4500.

**Please attach this needed documentation:**

- \_\_\_\_ Domain sheet and parent/guardian consent for evaluation
- \_\_\_\_ Educational screening form completed by teacher(s)
- \_\_\_\_ Appropriate medical information (current ocular for vision, audiological for hearing, medical for physical)
- \_\_\_\_ Appropriate educational information (i.e. IEP, #504 plan)
- \_\_\_\_ Appropriate administrative signatures (see below)
- \_\_\_\_ Class schedule (Jr. High and High School)

**Authorizations/Signatures:**

Referring Person \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

District Special Education Administrator \_\_\_\_\_ Date \_\_\_\_\_

Joint Agreement Director \_\_\_\_\_ Date \_\_\_\_\_

**It is the mission of CASE to collaborate as educational advocates for children with special needs in order to provide appropriate and high quality educational programs and services.**

**PARENT/GUARDIAN CONSENT FOR INITIAL EVALUATION**

DATE: \_\_\_\_\_ STUDENT'S NAME: \_\_\_\_\_ STUDENT'S DATE OF BIRTH: \_\_\_\_\_

Dear \_\_\_\_\_  
(Parent(s)/Guardian(s) Name)

Each school district shall ensure that a full and individual evaluation is conducted for each child being considered for special education and related services. The purpose of an evaluation is to determine:

- Whether the child has one or more disabilities;
- The present levels of academic achievement and functional performance of the child;
- Whether the disability is adversely affecting the child's education; and,
- Whether the child needs special education and related services.

An evaluation considers domains (areas related to the suspected disability) that may be relevant to the educational problems experienced by the individual child under consideration. The nature and intensity of the evaluation, including which domains will be addressed, will vary depending on the needs of your child and the type of existing information already available. The IEP Team, of which you are a member, determines the specific assessments needed to evaluate the individual needs of your child. Within 60 school days from the date of parent/guardian consent, a conference will be scheduled with you to discuss the findings and determine eligibility for special education and related services.

The IEP team must complete page 2 of this form prior to obtaining parental consent for evaluation.

**PARENT/GUARDIAN CONSENT FOR INITIAL EVALUATION**

I understand the school district must have my consent for the initial evaluation. If I refuse consent for an initial evaluation, the school district may, but is not required to, pursue override procedures through due process. If the school district chooses not to pursue such procedures, the school district is not in violation of the required evaluation procedures. I understand my rights as explained to me and contained in the **Explanation of Procedural Safeguards**. I understand the scope of the evaluation as described on page 2 of this form.

I give consent  I do not give consent to collect and/or review the evaluation data as described on page 2 of this form.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

**PARENT/GUARDIAN CONSENT FOR REEVALUATION**

DATE: \_\_\_\_\_ STUDENT'S NAME: \_\_\_\_\_ STUDENT'S DATE OF BIRTH: \_\_\_\_\_

Dear \_\_\_\_\_:  
(Parent(s)/Guardian(s) Name)

Each school district shall ensure that a reevaluation is conducted for each child being reconsidered for special education and related services. A reevaluation must occur at least once every three years unless the parent and school district agree that a reevaluation is not needed. A reevaluation may not occur more than once a year, unless the parent and school district agree it is necessary. The purpose of a reevaluation is to determine:

- Whether the child continues to have one or more disabilities;
- The present levels of academic achievement and functional performance of the child;
- Whether the disability is adversely affecting the child's education
- Whether the child continues to need special education and related services; and
- Whether any additions or modifications to the child's special education and related services are needed to enable the child to meet the measurable annual goals in the Individualized Education Program (IEP) and to participate appropriately in the general curriculum, extracurricular activities and other nonacademic activities.

An evaluation considers domains (areas related to the suspected disability) that may be relevant to the educational problems experienced by the individual child under consideration. The nature and intensity of the evaluation, including which domains will be addressed, will vary depending on the needs of your child and the type of existing information already available. The IEP Team, of which you are a member, determines the specific assessments needed to evaluate the individual needs of your child. Upon completion of your child's evaluation, a conference will be scheduled with you to discuss the findings and determine eligibility for special education and related services.

The IEP team must complete page 2 of this form prior to obtaining parental consent for a reevaluation. If the IEP team determines no additional evaluation is needed, then parental agreement and not parental consent is required.

**PARENT/GUARDIAN AGREEMENT THAT NO ADDITIONAL DATA IS NEEDED**

I understand the school district is not required to conduct a reevaluation to determine if my child continues to be a child with a disability. However, I may request the school district to conduct the reevaluation.

I agree  I do not agree with the determination that no additional data is needed

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

**PARENT/GUARDIAN CONSENT TO COLLECT ADDITIONAL EVALUATION DATA**

I understand the school district must have my consent for the reevaluation. If I refuse consent, the school district may, but is not required to, pursue override procedures through due process. If the school district chooses not to pursue such procedures, the school district is not in violation of the required evaluation procedure. Furthermore, I understand that if I fail to respond to the request for consent, the school district may pursue the reevaluation if the school district made reasonable efforts to obtain such consent. I understand my rights as explained to me and contained in the Explanation of Procedural Safeguards. I understand the scope of the evaluation as described on page 2 of this form.

I give consent  I do not give consent to collect the evaluation data as described on page 2 of this form.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**PARENT/GUARDIAN CONSENT FOR EVALUATION**  
**Identification of Needed Assessments**

<b>This form must be completed by the IEP Team</b>					
<b>DOMAIN</b>	<b>RELEVANT</b>		<b>EXISTING INFORMATION ABOUT THE CHILD</b>	<b>ADDITIONAL EVALUATION DATA NEEDED</b>	<b>SOURCES FROM WHICH DATA WILL BE OBTAINED</b>
	<b>YES</b>	<b>NO</b>			
<b>Academic Achievement</b> Current or past academic achievement data pertinent to current educational performance.					
<b>Functional Performance</b> Current or past functional performance data pertinent to current functional performance.					
<b>Cognitive Functioning</b> Data regarding cognitive ability, how the child takes in information, understands information and expresses information.					
<b>Communication Status</b> Information regarding communicative abilities (language, articulation, voice, fluency) affecting educational performance.					
<b>Health</b> Current or past medical difficulties affecting educational performance.					
<b>Hearing/Vision</b> Auditory/visual problems that would interfere with testing or educational performance. Dates and results of last hearing/visual test.				Vision Functioning Assessment	C.A.S.E. Itinerant Services 1104 N. Main Street Lombard, IL 60148 (630)629-2600
<b>Motor Abilities</b> Fine and gross motor coordination difficulties, functional mobility, or strength and endurance issues affecting educational performance.					
<b>Social/Emotional Status</b> Information regarding how the environment affects educational performance (life history, adaptive behavior, independent function, personal and social responsibility, cultural background).					

# Educational Screening Form for Students with Suspected or Confirmed Vision Problems

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender Male / Female

Primary Language \_\_\_\_\_ Grade \_\_\_\_ School \_\_\_\_\_ School Phone(\_\_\_\_)\_\_\_\_\_

Teacher: \_\_\_\_\_ Current related services \_\_\_\_\_

Current special education program: \_\_\_\_\_ Last Ocular Evaluation Date \_\_\_\_\_ (must be within one year)

Please have the teacher answer the following questions:

Please describe any concerns about this student's ability to use his/her vision:

---

---

Please describe the student's ability to utilize vision in the classroom setting for near vision?

---

---

Please describe the student's ability to utilize vision in the classroom setting for distance vision?

---

---

Teacher's questions about the student's use of vision?

---

---

Please describe where the student is seated in the classroom:

---

---

Please Answer The Following:

Does this student wear glasses?		YES	NO
Does this student see color?		YES	NO
In your opinion, does the child need specialized materials?		YES	NO
This student's overall academic skills?	HIGH	AVERAGE	LOW
Oral and written language skills?	HIGH	AVERAGE	LOW
Do you feel that this student's achievement reflects his/her potential?			

---

For modified/assisted programming students, please describe performance, functioning, and school environment for these students:

---

---

Additional Comments and Information: \_\_\_\_\_

---

---

Signed: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_