CASE
excellence through collaboration

Itinerant Services Office

1104 N. Main Street
Lombard, IL 60148-1362

Natalie Heinrich
Administrator

Mary M. Furbush, Ed.D.
Executive Director

630-629-2600, Relay Service 711
Fax 630-629-2601

Dear Educator:

The Cooperative Association for Special Education (CASE) is pleased to provide you the attached Low Incidence Referral Packet for hearing, and vision 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, or vision is suspected. The referral process should follow district procedures in accordance with state and federal statutes and regulations.

Please email or mail a copy of the completed itinerant referral to:

Natalie Heinrich
CASE Itinerant Services
1104 N. Main Street
Lombard, IL 60148
nheinrich@casedupage.com

When all referral materials are received, the student will be evaluated by a member of the CASE 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.

CASE 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,

Natalie Heinrich
CASE Administrator of Low Incidence Services

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REFERRAL FOR SERVICES

Student Name_____ Gender: ◯ M ◯ F Date of Birth_____

Home Phone: (_____)_____ Address_____ City_____ Zip_____

Parent(s)/Guardian(s):_____ Work/Cell Phone (_____)_____

Parent(s)/Guardians(s) Email: _____

Resident District: _____ Resident School: _____ Joint Agreement: _____

Attending District: _____ Attending School: _____ School Phone: (_____)_____

Attends: ◯ AM ◯ PM ◯ Full Day School Nurse: _____ Nurse Email: _____

Teacher: _____Teacher Email: _____

Specific concerns that led to this referral:

Assessment(s) Requested – check all that apply

☐ Functional Vision 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.

☐ 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 SASED DuPage West Cook. If you wish to request an audiological evaluation you will need to complete the referral to SASED DuPage West Cook. Please contact SASED 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 teachers___
___ Appropriate medical information (current ocular for vision, audiological for hearing, medically relevant information)
___ Appropriate educational information (i.e. IEP, #504 plan)
___ Appropriate administrative signatures (see below)
___ Class schedule (Jr. High and High School)

Referring Person: _____ Title: _____ Date: _____

District Special Education Administrator: _____ Date: _____

Joint Agreement Director: _____ Date: _____

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Educational Screening Form for Students with Suspected or Confirmed Vision Problems

Student Name: _____ Birthdate: _____ ☐ Male ☐ Female

Primary Language: _____ Grade: ____ School: _____ School Phone: (_____)_____

Teacher: _____ Current related services: _____

Current special education program: _____ Last Ocular Evaluation Date: _____ (must be within a year)

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:

_____

_____

List Teacher's questions about the student's use of vision:

_____

_____

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 this student's achievement reflects his/her potential? _____

_____

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

_____

_____

Additional comments and information: _____

_____

Signed: _____ Title: _____ Date: _____

The Cooperative Association for Special Education (CASE) is a 21st century organization that collaborates to provide special education services and support for students in our DuPage County member districts 15, 16, 41, 44, 87, 89, and 93.

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: _____

ISBE 34-578 (4/08)

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. 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 problem 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' 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. How- ever, 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: _____

ISBE 34-57C (4/08)

Student Name: _____ Date: ___/___/___

PARENT/GUARDIAN CONSENT FOR EVALUATION
Identification of Needed Assessments

This form must be completed by the IEP Team

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

ISBE 34-57 B/C (4/08)

Please discuss and complete each domain via your district IEP process