



Intermediate School District 917
Special Education Programs
1300 East 145 Street
Rosemount, Minnesota 55068-2999

**Referral for Services
 Within District 917**

Student's Name: _____ D.O.B.: _____ Grade: _____
 Primary Disability: _____ Secondary Disability: _____
 Parent/Guardian: _____ Phone: _____
 Address: _____ Email: _____
 City: _____ State: _____ Zip: _____
 Current Educational Placement/Program: _____ Location: _____
 917 IEP Manager: _____ Phone: _____

Services:

- | | | |
|--|--|---|
| <input type="checkbox"/> O.T. | <input type="checkbox"/> Visually Impaired* | <input type="checkbox"/> Physically Impaired* |
| <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Audiology* | <input type="checkbox"/> Physical Therapy* |
| <input type="checkbox"/> D.A.P.E. | <input type="checkbox"/> Deaf/Hard of Hearing* | <input type="checkbox"/> Other _____ |

Reason for Referral: _____

(Please include any psychological, social history, medical or educational data which would be of value in our planning for this referral.)

***Medical documentation for the following referrals must be included before this referral will be processed:**

- Deaf and Hard of Hearing - audiological documentation by a certified audiologist
- Physically Impaired - documentation of a medically diagnosed physical impairment
- Physical Therapy - doctor's prescription
- Vision - medical documentation of a diagnosed visual impairment by a doctor or ophthalmologist

Signature of Person Referring: _____ Date: _____

DISTRICT 917 USE ONLY

 Referring Assistant Director Date Assistant Director of Service Requested Date

Practitioner Assigned: _____ Date: _____

Date returned to referring program site secretary _____

Date copied to IEP Manager and put in learner file _____