***ADAMS WELLS SPECIAL SERVICES COOPERATIVE
Referral for Observation/Consultation***

|  |  |
| --- | --- |
| **Student Name:** | **School:**  |
| **Grade:**  | **Teacher:**  | **School Phone:** |
| **Individual Making Referral:**  | **Principal:** |
| **Building Contact to Receive Report:** |

|  |
| --- |
| ***Observation/Consultation Request From:*** |
|[ ]  Behavior Consultant  |
|[ ]  Assistive Technology Consultant |
|[ ]  Teacher for Blind Low Vision  |
|[ ]  Teacher for Deaf and Hard of Hearing  |
|[ ]  Orientation and Mobility Consultant  |
|[ ]  Other – Please Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please complete the following information:

|  |
| --- |
| 1. Is there a treatment history (psychiatrist, counselor/therapist, hospitalizations, medication, etc)?
 |
| Yes [ ]  | No [ ]  |
|  |
|  |
|  |
|  |

|  |
| --- |
| 1. List the problem behaviors (i.e., academic, behavioral, or other).
 |
|  |
|  |
|  |
|  |

|  |
| --- |
| 1. What interventions have been implemented to address these concerns? Please attach RTI intervention

documentation if available.  |
|  |
|  |
|  |
|  |

|  |
| --- |
| 1. In what way would you like the consultant to assist?
 |
|  |
|  |
|  |
|  |
| Next RtI meeting is schedule for the following: |
| Date:  | Time: |

***ADAMS WELLS SPECIAL SERVICES COOPERATIVE
Referral for Observation/Consultation***

|  |  |
| --- | --- |
| **Student Name:**  | **School:**  |
| **Grade:**  | **Teacher:**  | **School Phone:** |
| **Individual Making Referral:**  | **Principal:** |

Your child has been experiencing some difficulties at school. To further assist your child, we would like to request your permission for staff from Adams Wells Special Services Cooperative to provide services which may include observation, staff consultation, and student interviews, and non-diagnostic screeners or checklists. This consultation will be conducted at school to help improve your son’s/daughter’s learning experience.

If you have questions, please contact your son’s/daughter’s teacher.

Thank you for your cooperation.

|  |  |
| --- | --- |
|  | Yes**, I give permission** to provide the services described |
|  | No, **I DO NOT** give permission to provide the services described.  |

|  |  |
| --- | --- |
| Parent Signature: |  |
| Date: |  |  |

**\*Please email completed form to Courtney Baumgartner at****testing@awssc.k12.in.us**

**Signed form is valid for one year from date of signature unless written revocation of consent is received by Adams Wells Special Services Cooperative from the parent/guardian of the student.**

|  |
| --- |
| *For office use only:* |
| *Date received:* |

\*Form Updated 3/6/2024