

SAN FRANCISCO UNIFIED SCHOOL DISTRICT
Student Referral for Assessment*

- Referral Source**
 Student Success Team
 Parent/Guardian
 Agency/Hospital

HO# _____ Student _____ Date of Referral _____
Last Name, First Name

Gender	School	Grade	D. O.B.	Ethnicity
Parent/Guardian		Phone Number		Language of Home
Address		Student's Primary Language		Language Proficiency
ELD/BIL Services	Country of Origin	Yrs in U.S.	Grades Repeated	Classroom Teacher(s)

*Prior to an assessment, each site will be expected to complete the forms listed below. **Please retain the completed forms in the student's site SST folder (Speech & Language Checklist should be sent with this referral).***

- | | |
|---|--|
| <input type="checkbox"/> SST 1.0 Request for Assistance
<input type="checkbox"/> Vision Test (passed within 1 year)
<input type="checkbox"/> Hearing Test (passed within 1 year)

<input type="checkbox"/> SST 2.0 Meeting Summary (initial meeting)
Date of meeting _____

<input type="checkbox"/> SST 2.0A Follow-up Meeting(s) Summary(s)
Date(s) of follow-up meeting(s) _____

<input type="checkbox"/> SST 2.1 Teacher Input Form - Secondary
(for secondary students only) | <input type="checkbox"/> SST 3.0 Observation of Learning Environment

<input type="checkbox"/> SST 4.0 Developmental & Family Home Study

<input type="checkbox"/> Portfolio of Classroom Work
(Work Samples and curriculum-based assessments)

<input type="checkbox"/> SFUSD Language Survey
(For English Language Learners Only)

<input type="checkbox"/> Speech & Language Checklist (Must attach, with Speech Pathologist's signature, if referring for Speech/Language assessment)
Date(s) of SST meeting(s) _____ |
|---|--|

What are the specific referral concerns/issues?:

I, (print name) _____ have been informed of this referral and have received a copy of the "Notice of Procedural Safeguards" (CA Dept of Ed, Special Education Division, IDEA Part B)

_____ Date: _____
 (Parent/Guardian Signature)

Send (Do Not Fax) to:

Screening and Assessment Center
 1098 Harrison Street, 1/F
 San Francisco, CA 94103
 Phone: 355-6904

Date Sent*: _____

Sender's Signature*: _____

Sender's Position: _____

****Parent/Guardian must be notified of this referral***

Original to Cum folder / Copy to Screening and Assessment Center / Copy to SST folder