West End Special Education Local Plan Area

**EARLY START REFERRAL FOR PLACEMENT**

San Bernardino County Schools

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  | | |
| **To:** |  | | |
| **From:** |  | | |
| Student’s Name | | | |  | | | Birth Date |  |  |
| Parent’s Name | | | |  | | | Gender |  |  |
| Address | | | |  | | | Grade |  |  |
|  | | | |  | | | Disability |  |  |
| Phone | | | | (     )      -       Cell  Home  Work | | |  | |  |
| Phone | | | | (     )      -       Cell  Home  Work | | |  | |  |
| Phone | | | | (     )      -       Cell  Home  Work | | |  | |  |
| Home School | | |  | | | | |  |
| District of Residence | | |  | | | | |  |
| Initial Early Start Referral Date | | | |  | | | |  |

Client of Inland Regional Center

SBCSS Solely Low Incidence

DHH

Visually Impaired

Orthopedic Impairment

This student is being referred for placement in the SBCSS Early Start Program.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| The following documents are attached (check appropriate): | | | | |
| Current Individualized Family Service Plan (IFSP) | | | | |
| Initial Referral Page | | | | |
|  | Referred by:  Parent  IRC  OTHER: | | | |
| Intake Reports | | | | |
|  | PT  OT  SLP  DHH Specialist  VI Teacher  OTHER: | | | |
|  | | | |  |
|  | | | |
|  | | | |
|  | |  |  |  |
|  | |  |  |  |
|  | | Director’s Signature |  | Date |