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.

|  |
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| 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 |