



Excellence Together

COOPERATIVE ASSOCIATION for SPECIAL EDUCATION

Itinerant Services Office

1104 N Main Street
Lombard IL 60148-1362

Voice or TTY (630) 629-2600
FAX (630) 629-2601

Georgia J. Peceniak
Executive Director

REFERRAL FOR SERVICES

Referral Information:

Student Name _____ Gender: Male/Female Date of Birth _____

Home Phone (____) _____ Address _____ City _____ Zip _____

Parent(s)/Guardian(s) _____ Work/Cell phone (____) _____

Joint Agreement _____ Attending School _____ District _____

Teacher's Name _____ Grade _____ Attends: AM only, PM only, Full day

School Nurse _____ School Phone(____) _____

Specific concerns that led to this referral: _____

Type of evaluation requested:

____ Vision Functioning Assessment

Upon receipt of the referral a Functional Vision Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

Please note: An Orientation and Mobility Assessment can be requested if the student is currently receiving vision itinerant services or at the same time a request is made for a Vision Functioning Assessment.

____ Physical Functioning Assessment

Upon receipt of the referral a Physical Functional observation and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

____ Hearing Functioning Assessment

Upon receipt of the referral a Functional Hearing Assessment and/or a review of records will be completed. A comprehensive report will be completed and will include a list of accommodations and recommendations.

Please note: Audiological evaluations are completed through SASSED DuPage West Cook. If you wish to request an audiological evaluation you will need to complete the referral to SASSED Dupage West Cook. Please contact SASSED DuPage West Cook directly at (630) 778-4500.

Please attach this needed documentation:

- ____ Domain sheet and parent/guardian consent for evaluation
- ____ Educational screening form completed by teacher(s)
- ____ Appropriate medical information (current ocular for vision, audiological for hearing, medical for physical)
- ____ Appropriate educational information (i.e. IEP, #504 plan)
- ____ Appropriate administrative signatures (see below)
- ____ Class schedule (Jr. High and High School)

Authorizations/Signatures:

Referring Person _____ Title _____ Date _____

District Special Education Administrator _____ Date _____

Joint Agreement Director _____ Date _____

It is the mission of CASE to collaborate as educational advocates for children with special needs in order to provide appropriate and high quality educational programs and services.