WEEDSPORT CENTRAL SCHOOL DISTRICT

Committee on Pre-School Special Education (CPSE) Referral

Child's Name: _____ _____/_____/_____
Last First Middle Initial Date of Birth

Parent's Name _____
Last First

Home Address:_____
Street City State Zip

Contact Information: _____ (____)_____ (____)_____
Email Address Home Phone Mobile

Pre-School Teacher's Name (if applicable): _____
Last name First name

Referral Source for this form: _____ Parent _____Teacher

If solely teacher referral, provide the date parent was notified: _____

Reason for Referral: _____

_____

_____

List any Early Intervention services this child received: _____

List any CPSE services this child currently receives: _____

Indicate any known pre/post-natal complications for this child: _____

_____

_____

Describe this child's general health: _____

Describe this child's vision: _____

Describe this child's hearing: _____

Is this child toilet-trained? _____Yes _____No

Is this child taking any medications? _____Yes _____No If Yes, for what purpose: _____

_____

From your experience, mark an X for each statement that describes the child:

Sensory

	Overly sensitive to noise
	Seeks noise, inappropriate noise making
	Enjoys watching things spin
	Mouths items frequently
	Seeks movement-spinning, bouncing, jumping
	Has difficulty sitting still, staying in seat
	Avoids being touched
	Avoids messy activities
	Demonstrates repetitive behavior- turning lights on/off, zipping/unzipping, etc.
	Demonstrates rigidity in routine
	Unaware of when face/hands need to be cleaned
	Other:

Fine Motor

	Cannot use crayons or pencils with correct grip
	Cannot use scissors with correct grip
	Uses too much or too little pressure when writing
	Does not cross midline
	Switches hands frequently when using fine motor tools
	Cannot imitate horizontal/vertical/circular motions on paper
	Other:

Gross Motor

	Cannot walk safely- trips, falls, or bumps into things
	Cannot run safely- trips, falls, or bumps into things
	Cannot jump in place
	Cannot navigate stairs
	Cannot toss items underhand towards a target
	Cannot throw items overhand towards a target
	Other:

Speech/Language

	Cannot follow one-step or two-step directions
	Cannot speak in complete words
	Cannot orally express his/her wants/needs
	Cannot speak in complete sentences
	Cannot be understood when speaking to an unfamiliar listener
	Cannot name common objects
	Cannot use pronouns
	Cannot retell a story or answer questions about the story
	Other:

Pre-Academic/Academic

	Cannot listen to a story from start to finish
	Cannot tell first and last name
	Cannot recognize first name
	Cannot recognize last name
	Cannot write letters or numbers
	Cannot write first name
	Cannot identify colors
	Cannot identify shapes (circle, square, triangle, rectangle)
	Cannot identify numbers to 10
	Other:

Behavioral

	Exhibits frequent crying
	Exhibits frequent tantrums
	Exhibits destructiveness (breaks things out of frustration and/or anger)
	Exhibits difficulty complying with adult authority
	Other:

For the reasons indicated on this referral form, I believe this child requires an evaluation to
- determine the existence of a disability and eligibility to receive CPSE services, or
- investigate the need for further services for a child who is already classified.

_____ _____

Print name of referring person | Title/Relationship to child

_____ _____

Signature of referring person | Date

Please return this form to:

Ann DeFazio
Director of Special Programs
2821 East Brutus Street
Weedsport, NY 13166
315-834-8186