SPEED S.E.J.A. #802
1125 Division Street
Chicago Heights, Illinois 60411-2491

Telephone: 708/481-6100
TDD: 708/481-6100
Fax: 708/481-5713

Date of Referral:	**District:**	**Student's School:**	**Grade:**
Referral Person:		Position:	Phone:

Student's Name: _____
Last First

Address: _____

City: _____ Zip: _____

Birth date: _____ Sex: ☐ M ☐ F

Date of Initial Consent for Placement: _____

Date of Initial Eligibility: _____

Date of Last IEP Meeting: _____

Date of Last Eligibility Meeting: _____

Primary Language: _____

Primary Mode of Communication: _____

Primary Disability: _____

Student SIS #: _____

Student Soc Sec #: _____ Medicaid #: _____

Parent/Legal Guardian: _____ Phone: _____

Foster Parent: _____ Phone: _____

DCFS Caseworker: _____ Phone: _____

_____ _____
Referring Person's Signature Date

_____ _____
LEA Representative Date

EDUCATIONAL SERVICES

☐ Vision Itinerant
☐ Deaf & Hard of Hearing Itinerant
☐ Functional Vision Assessment
☐ Assistive Technology Consult
☐ Occupational Therapy
☐ Physical Therapy
☐ Technical Assistance
☐ Individual Student Consult
☐ Classroom Consult
☐ Programmatic Consult
☐ Behavior Interventions
☐ Other _____

Contact Person: _____
_____

EDUCATIONAL PROGRAMS

☐ Early Learning Center (ELC)
☐ Program for Adaptive Learning (PAL)
☐ Independence Elementary School (IES)
☐ Independence High School (IHS)
☐ Academy for Lifelong Learning (ALL) (Transition Program)
☐ Deaf & Hard of Hearing High School Instructional Program
☐ CIBS (Crisis Intervention Behavior Stabilization) Program K-12+

Include in the Referral Packet:
1. Current Case Study w/ domain reports
2. Current IEP
3. Functional Behavior Analysis & Behavior Intervention Plan
4. H.S. Transcripts (if applicable)
5. Discipline Records (include # of days suspended, if applicable)
6. Medical / Health Records
7. Transportation needs (i.e. safety vest, monitor, preferential seating)

Reason for Referral/ Comments: