

## STUDENT EDUCATIONAL REFERRAL REQUEST FORM

**Please scan all documentation to email directly to:**  
[learningservices@gypsd.ca](mailto:learningservices@gypsd.ca)

|   |                            |                      |
|---|----------------------------|----------------------|
| Student Name:   |                            |                      |
| D.O.B.: dd/mm/year  | Grade:                     | AB ED Student I.D.#: |
| School:   |                            | Main Teacher:        |
| Parent(s)/Legal Guardian(s):                                |                            |                      |
| Mailing Address:  |                            | Telephone:           |
| If coded, give #:   | Previously coded?<br>Year: | Code #:              |
| Previously received psycho-educational assessment (yes/no): | Date/year of assessment:   |                      |

**Student is receiving following services (check only those that apply):**

| check box                | Type of Service  |
|--------------------------|--|
| <input type="checkbox"/> | speech/language  |
| <input type="checkbox"/> | occupational therapy   |
| <input type="checkbox"/> | physical therapy   |
| <input type="checkbox"/> | in-school counseling   |
| <input type="checkbox"/> | family school liaison counsellor/family student therapist assistance |
|                          | <b>Other? (Specify</b>   |

**Please provide information in the following areas:**

| Does student have or experience:   | Check Box                    | If yes, how are they being addressed or explain? |
|--|------------------------------|--|
| vision difficulties?   | Yes <input type="checkbox"/> |  |
|  | No <input type="checkbox"/>  |  |
| When was the last vision assessment?<br>If not in the last year, please have this completed before sending the form in.  |                              |  |
| hearing difficulties?  | Yes <input type="checkbox"/> |  |
|  | No <input type="checkbox"/>  |  |
| When was the last hearing assessment?<br>If not in the last year, please have this completed before sending the form in. |                              |  |

|                            |                              |  |
|----------------------------|------------------------------|--|
| current medical assessment | Yes <input type="checkbox"/> |  |
|                            | No <input type="checkbox"/>  |  |

| <b>Student Referral Request: SUBMISSION REQUIREMENTS</b><br>(School-based-team decision based on classroom observations, FBAs, student assessments)   | <b>Teacher Checklist</b> |
|---|--------------------------|
| Functional Behavioral Assessment *(if a behavior assessment is requested)   | <input type="checkbox"/> |
| Level B Assessments: <ul style="list-style-type: none"> <li>WJIV results summary sheet, which must have been completed in the last 6 months.</li> </ul>   | <input type="checkbox"/> |
| Classroom teacher one-page executive summary of the student (all aspects)   | <input type="checkbox"/> |
| Why a request for an Educational Psychological Assessment is being requested – (determine if the student has a cognitive or learning disability, programming recommendations, AISH, Diploma accommodations) | <input type="checkbox"/> |
| Previous psychological-educational assessments  | <input type="checkbox"/> |
| Current school year speech-language pathologist reports/assessments   | <input type="checkbox"/> |
| Counseling/FSLC information   | <input type="checkbox"/> |
| Copy of current student IPP   | <input type="checkbox"/> |
| Student assessment referral request (achievement/cognitive/behavioral)  | <input type="checkbox"/> |

Learning Services Approval: \_\_\_\_\_ Date: \_\_\_\_\_

| <b>check box</b>         | <b>Services to be provided</b>               |
|--------------------------|--|
| <input type="checkbox"/> | Cognitive Ability Assessment: comments(s)    |
| <input type="checkbox"/> | Cognitive Achievement Assessment: comment(s) |
| <input type="checkbox"/> | Behavior Assessment: comment(s)              |
|                          | Other:                                       |

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the parent refuses to agree to the assessment, please note this directly on the student referral form and student IPP. (Please sign and date).

**Parents (to be completed after IL Supervisor has been informed):**

I have read and discussed the above information and agree to an individual assessment of my child by contract psychologists hired by GYPSD#77. I understand that my child's assessment date and time may need to be rescheduled due to unforeseen circumstances.

Parent's/Guardian's:

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date