Department of Special Services
(432) 456.8719
www.ectorcountyisd.org

ECISD Special Education

REFERRAL ITEM CHECKLIST			
Last Name:	First Name:	Grade:	Campus:
Date of Birth:	ID Number:	Teacher's Name:	
Parent Name:		Parent Phone Number:	

DATE	
	Does the student already receive Special Education Services? ☐ **YES** ☐ **NO** (If **YES,** all requests for additional evaluation **MUST** go through the ARD committee)
	Vision and Hearing Screening **NOTE: Student must pass hearing screening. The vision screening must indicate 20/70 or better vision (unless visual impairment is suspected). **DO NOT PROCEED WITH REFERRAL IF THIS CRITERIA IS NOT MET**
	RTI Documentation
	504/Dyslexia Program Documentation (attached if applicable)
	Home Language Survey
	LPAC Documentation
	Discipline Reports Copies of Office Level Discipline Referral/s
	Permanent Record Card Has the student been retained? **YES** **NO** If **YES**, what grade level(s) and what was the reason?
	Student Information Card (SIC)
	State/District Benchmark Scores/iStation/CogAT/TELPAS/STAAR
	Historical Grades Report & Most Current Progress Report
	Current and Historical Attendance Data
	Teacher Information
	Parent Information
	Communication Information
	Classroom Observation
	Assistive Technology Checklist
	Student Work – 3-4 samples in area or areas of suspected disability. NO STAAR PASSAGES, please.

I certify that all of the above documentation is completed and included in this referral. I understand that incomplete referrals will be returned to the campus.

_____ _____

Signature Date