



SOUTHEAST REGIONAL COOPERATIVE

1200 W. Speedway Blvd / PO Box 85000 Tucson, AZ 85754
(520) 770-3200 / (520) 770-3782 fax

REQUEST FOR ASSISTANCE

Student's **Legal** Name: _____ DOB: _____ Ethnicity: _____ M F

School District: _____

School of Attendance: _____ School Phone: _____

School Address: _____ City, Zip: _____

Student's Grade Level: _____ SAIS #: _____

Suspected Area of Concern – Hearing: _____ Vision: _____

Classroom Teacher(s): _____

Parents/Guardians: _____ Home Language: _____

Home Address: _____ City, Zip: _____

Phone: (H) _____ (W) _____

Reason for Referral:

Does student have current IEP/IFSP and/or Eligibility Statement?

YES NO (Attach all supporting information)

Services Requested:

- Hearing Evaluation (**attach** previous audiograms or test results) **and / or** Educational Evaluation for student, if appropriate)
- Assistance with Vision Screening
- Functional Vision Assessment (MUST **attach** ophthalmological or optometric information)
- Orientation and Mobility Evaluation
- Student transferring to district with **current IEP & Eligibility** as VI or HI (**circle one**) student.
- Transitioning to Preschool

Attach hearing and/or vision information, current IEP & Comprehensive Evaluation (if available).

VISION REFERRALS WITHOUT ATTACHED VISION REPORTS WILL BE SENT BACK.

DO NOT obtain Permission to Evaluate, at this time.

Does student have other physical or learning challenges?

Additional Comments:

Referred By: _____ Title: _____
Email: _____ Phone: _____

X _____ / _____
Print Sp. Ed. Director/Designee Signature Date