COLUMBIA REGIONAL
INCLUSIVE SERVICES
833 NE 74th Ave. Portland, OR 97213
Phone: 503.916.5570 Fax: 503.916.5576
crisoregon.org

Student Referral Form

OFFICE USE ONLY

Step 1: Tell us about the source of this referral

Date of Referral	Referring School District/Education Agency			
Person Submitting the Referral	Position	Phone	Ext	Email
Case Manager/Service Coordinator	Position	Phone	Ext	Email

Step 2: Tell us about the student being referred

Student First Name		Last Name		Initial	Gender	Date of Birth
Grade	SSID#	Child/Student ID	Current Special Education Eligibilities			Out of state move-in ☐Yes ☐No
For ELL/Culturally and Linguistically Diverse Students (describe relevant background, language, needs)						Interpreter needed ☐Yes ☐No
Home Address		Apt/Unit #	City	State		Zip
Parent/Caregiver #1		Relationship	Phone	Email		
Parent/Caregiver #2		Relationship	Phone	Email		
Resident School		Resident District		County		
Attending School		Attending District		ESD Placement? If so name:		

Step 3: Tell us which services are being requested, note required documents

AUTISM SPECTRUM DISORDER (ASD)

☐ Assistance with an evaluation and determining eligibility under Autism Spectrum Disorder (82)

☐ Initiate support from an autism specialist; student has an existing ASD eligibility
REQUIRED: copy of the current ASD eligibility statement with this referral

BLIND AND LOW VISION (BLV)

☐ Assistance with an evaluation and determining eligibility under Vision Impairment (40)
REQUIRED: copy of an Eye Report from an ophthalmologist or optometrist

☐ Initiate services from a Teacher of the Visually Impaired; student has an existing VI eligibility
REQUIRED: copy of the current VI eligibility statement with this referral
REQUIRED: copy of the current IEP or IFSP
IF AVAILABLE: copy of the Eye Report, Functional Vision Assessment, and Learning Media Assessment

DEAFBLINDNESS (DB)

☐ Assistance with an evaluation and determining eligibility under DeafBlindness (43)
REQUIRED: copy of Audiogram and Eye Report

☐ Initiate services for a student with an existing DB eligibility
REQUIRED: copy of current DB eligibility statement with this referral

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DEAF & HARD OF HEARING (DHH)

☐ Assistance with an evaluation and determining eligibility under Deaf or Hard of Hearing (20)
REQUIRED: copy of current audiogram with this referral

☐ Audiological evaluation (only available to children ages birth-to-five)
REQUIRED: documentation of two failed hearing screenings

☐ Initiate services from a Teacher of the Deaf or Hard of Hearing; student has an existing DHH eligibility
REQUIRED: copy of the current DHH eligibility statement with this referral
REQUIRED: copy of the current IEP or IFSP
IF AVAILABLE: copy of current audiogram and medical or health assessment statement

ORTHOPEDIC IMPAIRMENT (OI) & AT/AAC SERVICES

☐ Request Augmentative and Alternative Communication (AAC) consultation
REQUIRED: copy of the current Orthopedic Impairment (70) eligibility statement OR eligibility statement if requesting consultation for a different regional eligibility (ASD, TBI) to be submitted with this referral
REQUIRED: complete the AT/AAC Learner Profile with this referral; link to EI/ECSE or School-Aged form

☐ Request Assistive Technology (AT) consultation
REQUIRED: copy of the current Orthopedic Impairment (70) eligibility statement with this referral
REQUIRED: complete the AT/AAC Learner Profile with this referral; link to EI/ECSE or School-Aged form

☐ Loan of student equipment (motor, AT, AAC)
REQUIRED: copy of the current Orthopedic Impairment (70) eligibility statement OR eligibility statement if requesting for a different regional eligibility (ASD, TBI) to be submitted with this referral

TRAUMATIC BRAIN INJURY (TBI)

☐ Technical assistance with evaluation and determining eligibility under Traumatic Brain Injury (74)

☐ Initiate specialist support for a student with an existing TBI eligibility
REQUIRED: copy of the current TBI eligibility statement with this referral

Step 4: Obtain signed approval and submit this referral along with required documents

Have any meetings for this student been scheduled that we should know about? Any comments or special considerations?

_____
PRINTED NAME of Special Education Director or Designee

X_____ _____
SIGNATURE of Special Education Director or Designee **Date Signed**

Submit via fax or mail. **Fax:** 503.916.5576 **Email:** lmaples@pps.net

A CRIS staff member will contact the person who submitted the referral. If you have questions regarding the status of a referral, call us at 503.916.5570. Additional information regarding the referral process is available on the Student Referral page.

Referrals that are incomplete, unsigned, or that do not include required paperwork will be held for up to sixty days while we attempt to reach the person who submitted the referral to obtain the missing information or paperwork.