

**CHESTER COUNTY INTERMEDIATE UNIT**

**STUDENT SERVICES / CASE / STEPS**

**CLASS / PROGRAM REFERRAL FORM**

Name of Student: \_\_\_\_\_

Date of Referral: \_\_\_\_\_ PAMail Number \_\_\_\_\_

School District: \_\_\_\_\_ School: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Parent Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**REFERRING DISTRICT INFORMATION**

Individual Authorizing Referral: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Person (if different than authorized person):

Name \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number of Contact Person: \_\_\_\_\_ E-Mail Address of Contact Person: \_\_\_\_\_

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**For IU use:**

**PROGRAM/CLASS REFERRAL**

Discussion with Other Internal Referral Sources

(If Appropriate): \_\_\_\_ Yes \_\_\_\_ N/A

Who: \_\_\_\_\_ Date: \_\_\_\_\_

Who Designated to Contact District Person: \_\_\_\_\_

Status of Referral: \_\_\_\_ Accepted \_\_\_\_ Not Accepted

If Accepted, Tentative Beginning Date: \_\_\_\_\_

Date of Response to District Contact Person: \_\_\_\_\_

If not within 10 days, cite reason why \_\_\_\_\_

Date of Verification by District that Transportation is Arranged: \_\_\_\_\_

Date Medical Records Requested: \_\_\_\_\_

**PROGRAM/CLASS REFERRAL**

<b>PLEASE CHECK APPROPRIATE PROGRAMS</b>		<b>IU CONTACT</b>
Child and Career Development Center Specify Type of Class:		Sue Mateka 610-383-7400, Suem@cciu.org
Center for Alternative Secondary Education Specify whether Regular or Special Ed Student:		Lisa Tzanakis 610-486-2273, Lisat@cciu.org
STEPS Specify whether Regular or Special Ed Student:		Lisa Tzanakis 610-486-2273, Lisat@cciu.org
Cross District Emotional Support Class		Jacalyn Auris 484-237-5039, Jacalyna@cciu.org
Cross District Life Skills Support Class		Jacalyn Auris 484-237-5039, Jacalyna@cciu.org
Cross District Multiple Disabilities Support Class		Jacalyn Auris 484-237-5039, Jacalyna@cciu.org
Cross District Autism Support Class		Lorrie Steele 484-237-5029, Lorries@cciu.org
IU Partial Hospitalization or Mental Health Based Programs Specify whether CARE, REACH, TEACH or RISE:		Sue Lombardi 610-380-2258, Suel@cciu.org
Cross District Hearing Class		Vince McVeigh 484-237-5013, Vincem@cciu.org
Speech and Language Services		Lillian Neary 484-237-5045, Lilliann@cciu.org
Home and Community Services (Wraparound/Personal Care Assistants)		Cathy Scanlon 484-237-5192, Catherines@cciu.org
WCU/CCIU Community Classroom		Jacalyn Auris 484-237-5039, Jacalyna@cciu.org
Transitional Living Program (TLP)		Jacalyn Auris 484-237-5039, Jacalyna@cciu.org
CHANGES		Sue Lombardi 610-380-2258, Suel@cciu.org
CHOICES		Cris Chambers 484-237-5064, Crisc@cciu.org
PAAL		Ann Henry 484-237-5131, Annh@cciu.org
Psychological Services/Evaluation		Cris Chambers 484-237-5064, Crisc@cciu.org

Reason for Referral/Areas of Concern:

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**REQUIRED INFORMATION ATTACHED FOR PROGRAM / CLASS REFERRAL**

IEP: \_\_\_\_\_ Yes (Date Implemented: \_\_\_\_\_) \_\_\_\_\_ No \_\_\_\_\_ N/A  
504 Services Agreement Plan: \_\_\_\_\_ Yes (Date Implemented: \_\_\_\_\_) \_\_\_\_\_ No \_\_\_\_\_ N/A  
NOREP: \_\_\_\_\_ Yes (Date Signed: \_\_\_\_\_) \_\_\_\_\_ No \_\_\_\_\_ N/A  
Evaluation Report: \_\_\_\_\_ Yes (Date of Report: \_\_\_\_\_) \_\_\_\_\_ No \_\_\_\_\_ N/A

**FOR REACH & TEACH:** Has Dr. Newbrough conducted an evaluation of the student: \_\_\_ Yes \_\_\_ No If yes, Please Attach

**FOR SECONDARY STUDENTS:** Transcripts Attached: \_\_\_ Yes \_\_\_ No; Attendance Record Attached: \_\_\_ Yes \_\_\_ No

**FOR CASE/STEPS:** Days of Suspension this year \_\_\_\_\_ Any Eval Needed: \_\_\_\_\_ Yes, Specify: \_\_\_\_\_  
\_\_\_\_\_ No

Length of Stay: \_\_\_\_\_ Regular (45 day minimum)  
\_\_\_\_\_ Diagnostic (Up to 45 days)  
\_\_\_\_\_ Expulsion (Length of Expulsion: \_\_\_\_\_)  
\_\_\_\_\_ Transitional (Alternative placement to Home District)  
\_\_\_\_\_ Other: \_\_\_\_\_

Can student return mid-marking period if level achieved? \_\_\_\_\_ Yes \_\_\_\_\_ No