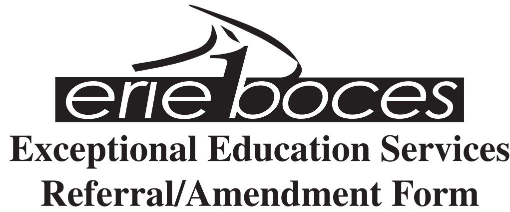
(BOCES Use Only)
Date Rec'd_______________________
Tchr Asgn'd______________________
Start Date _______________________
Location ________________________



Exceptional Education Services Referral/Amendment Form

District______________________

School Year Requested _________

❑ American Indian/Alaskan
❑ Asian/Pacific Islander
❑ Black ❑ White
❑ Hispanic ❑ Multi-racial

Student Name ________________________________ Parent/Guardian________________________________

D.O.B.______________ Age 12/1 for yr requested ________________ Classification: _________ Phone __________________

❑ SELF CONTAINED CLASS PLACEMENT REQUEST (Initial Placement Only)

a) **CURRICULUM FOCUS:** ❑ Gen. Ed. ❑ Mod. Gen. Ed. ❑ State Assessments ❑ NYSAA
CLASS SIZE: ❑ 6:1+A ❑ 8:1+A ❑ 12:1+A ❑ 9:1+3A
LEVEL: ❑ Elementary ❑ Middle ❑ High
DIPLOMA: ❑ Not determined ❑ IEP ❑ Local ❑ Regents
OTHER: ❑ CPC

b) Full Scale: ____________ G.E. Reading: _________________ Grade for year requested: ________________________
G.E. Math: __________________ Cohort year: ________________________________

c) Current Placement/class size:____

d) Reason for Referral: ____

____

e) **Required Documentation (must be attached):** ❑ IEP ❑ Health/Immunization ❑ Psychological ❑ Social History
❑ FBA/BIP ❑ H.S. Transcripts/Report Cards ❑ Total Credits Earned:______ ❑ OT Prescription ❑ PT Prescription
❑ Documentation from Releasing Agency (if applicable) ❑ Provider Report (if applicable)

❑ SERVICES PROVIDED BY BOCES ❑ Self-Contained with the following services ❑ Related Services Only

a) SP-2 per week minimum. We do not offer PT Group. If agency is used for any service/s listed on IEP, complete line c.

SP, Gr. __________	freq./wk	Itin. Hearing ____________	freq./wk	Counseling, Gr.______	freq./wk
SP, Ind. __________	freq./wk	Hearing R.R.____________	freq./wk	Counseling, Ind.______	freq./wk
SP Consult _______	hrs./yr.	Hearing Consult _________	hrs./yr.	Counseling Consult __	hrs./yr.
OT, Gr. __________	freq./wk	Itin. Vision _____________	freq./wk	Per. Aide ___________	
OT, Ind.__________	freq./wk	Vision Materials Support____	hrs./yr.	LPN Aide __________	
OT Consult _______	hrs./yr.	Vision Consult __________	hrs./yr.	ASD consultation ____	
PT, Ind. __________	freq./wk				
PT Consult _______	hrs./yr.	Other Services/Evals______________________________			

b) For District Based Students: Grade ____________________ Class Size ___________ Building ___________________

c) Related Services provided by Agency/district:____

____

❑ AMENDMENT TO SERVICES FOR A CURRENTLY-SERVED STUDENT The attached IEP represents amendment(s) to the program of a student currently receiving services from Erie 1 BOCES:

	From Current Services	To New Services
Change:	___________________________	____________________________
Site:	___________________________	____________________________
Effective Date:	___________________________	____________________________

Signature (required for all referrals) Phone Date

Distribution: White - BOCES Yellow - Teacher Pink - District

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