

**LOW INCIDENCE REFERRAL  
PROCESS**

**DEAF  
HARD OF HEARING  
VISUALLY IMPAIRED  
ORIENTATION MOBILITY  
ORTHOPEDICALLY IMPAIRED**

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**Special Education  
Low Incidence Referral Process 2006/2007**

For the 2006/2007 school year, please use the chart below for referrals for low incidence services:

<b>DIS Service</b>	<b>Regional Service Provider District</b>	<b>Contact Person</b>	<b>Supervisor of Program</b>	<b>Mail referral to:</b>
DHH Special Day Class	Palmdale School District	Jamie Ross 947-3863	Jamie Ross	JET: PSD/DO Jamie Ross
DHH Itinerant Services	Palmdale School District	Jamie Ross 947-3863	Jamie Ross	JET: PSD/Summerwind ATTN: Jamie Ross
Visually Impaired Itinerant Teacher	Lancaster School District	Dori Krejmas 942-1115	Donna Parks 942-1115	JET: LSD/Linda Verde Center ATTN: Donna Parks
Visually Impaired Orientation and Mobility Itinerant Teacher	Lancaster School District	Paul Lund 951-1127	Donna Parks 942-1115	JET: LSD/Linda Verde Center ATTN: Donna Parks
Orthopedically Impaired Itinerant Teacher	Lancaster School District	Peter Clarkson – (High School) 942-1115 Debra Rondeau (Elementary)	Donna Parks 942-1115	JET: LSD/Linda Verde Center ATTN: Donna Parks

## Antelope Valley Special Education Local Plan Area (SELPA)

### Directions for requesting REGIONAL/LOW INCIDENCE SERVICES

Districts with students who have low incidence disabilities who may require designated instructional services or special day class placement, may access those services through the SELPA designated provider district. Please see the attached chart to identify the provider, and follow the process indicated below:

#### 1. Early Start Referrals:

Early Start Referrals should go directly to the Early Start Coordinator. Please use the two page **Referral for Regional/Low Incidence Services** form. (See mailing address on next sheet)

#### 2. Referral process for new low incidence DIS services not previously designated:

For a new DIS service not previously designated on an IEP, the determination of need for services is established through a two step process:

##### A. Request for Observation/Screening

##### B. Referral for Assessment

##### A. Request for Observation/Screening

1. Complete the **Regional/Low Incidence Services - Request for Observation/Screening** form.
2. You **must** attach the following:
  - copies of all necessary physician reports

**All requests not accompanied by this information will be returned.**

3. **Jet mail/deliver/FAX** request with pertinent information to the appropriate location.
4. All requests will be logged when received. Observations should be accomplished within a reasonable period of time (2-3 weeks). The observation/screening results will be returned to the contact person indicated on the form. Follow-up contact may be made directly with appropriate personnel.
5. If the results indicate that the student would not be eligible for consideration of services, and you wish to obtain additional information, please contact the Itinerant specialist directly.
6. If further assessment is indicated, the **Request for Observation/Screening** report and a completed **Assessment Plan** will be returned to you. Please complete the **Referral for Regional/Low Incidence Services** form, and send it along with the signed assessment plan to the Regional Service Provider.

**B. Referral for assessment to determine eligibility for new Regional Services:**

1. Complete the **Referral for Regional/Low Incidence Services** form – 2 pages.
2. **Jet mail/deliver** to appropriate individual.
3. If the regional service provider has been unsuccessful in contacting the parent/guardian three times, a call will be made to the contact person on the referral form to inform them of our inability to reach the parents, and the referral may be returned to the home district.

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**3. Referral process for parallel transfers (Early Start, DIS VI/OI/DHH itinerant services or DHH Special Day Class):**

1. Complete the two page **Referral for Regional/Low Incidence Services** form, indicating the parallel transfer box. A current IEP must be attached.
2. **Jet Mail/Deliver** to appropriate individual.
3. If the regional service provider has been unsuccessful in contacting the parent/guardian three times, a call will be made to the contact person on the referral form to inform them of our inability to reach the parents, and the referral may be returned to the home district.

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**Forms:**

1. **Regional/Low Incidence Services - Request for Observation/Screening**
2. **Referral for Regional/Low Incidence Services**

**Antelope Valley Special Education Local Plan Area  
Regional/Low Incidence Services  
Request for Observation/Screening**

<b>Do not write in this space</b>	
Date Rcvd.	Initials

Date of Request		Type of Observation/Screening requested:	
Person submitting request:	Phone:	<input type="checkbox"/> Audiologist <input type="checkbox"/> Hard of Hearing/Deaf Itinerant teacher <input type="checkbox"/> Orthopedically Impaired Itinerant Teacher	<input type="checkbox"/> Visually Impaired Itinerant Teacher <input type="checkbox"/> Orientation/Mobility Teacher
Name of Student (Last, First, Middle initial)		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate (mm/dd/yy)
Parent/Guardian:	Address:		Phone:
Name of School:	District of Attendance:		School phone:
Contact person at school site/ title:	Language in Home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		Grade:      Track:
For vision or hearing referrals you <b>must attach</b> copy of a <b>physician's vision or hearing report</b> , preferably no more than one year old. Orthopedically impaired children should also have an <b>attached physician</b> report confirming an orthopedic diagnosis. <input type="checkbox"/> <b>Medical records attached</b>			
Specify areas of concern (how does area of suspected disability affect the student's performance in the school setting):			
<input type="checkbox"/> Functional Skills Curriculum <input type="checkbox"/> Academic Levels: Reading _____ Written Language _____ Math _____			
Section II- To be filled out by Itinerant specialist - Results of observation:			
Date completed by itinerant specialist:		Date mailed to home school:	
Recommendation: <input type="checkbox"/> Further assessment needed – please return signed Assessment Plan (202) and Referral Form <input type="checkbox"/> No further assessment needed-see attached ideas for modifying regular program <input type="checkbox"/> Child within normal limits – no interventions needed			

Distribution:      copy 1 – referring teacher      copy 2 – Regional Service Provider/District Office      copy 3 – school nurse

\_\_\_\_\_  
Site Administrator(may be optional per your District policy)

\_\_\_\_\_  
District Administrator (may be optional per your District policy)

ANTELOPE VALLEY SPECIAL EDUCATION LOCAL PLAN AREA  
REFERRAL FOR REGIONAL/LOW INCIDENCE SERVICES

Do not write in this space	
Date Rcvd.	Initials

- Parallel transfer (IEP must be attached)
- Referral to determine eligibility for specialized services

Date of referral: \_\_\_\_\_ Referring District: \_\_\_\_\_  
Service being requested: \_\_\_\_\_  
Contact person: \_\_\_\_\_ Phone number \_\_\_\_\_

Student Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_ Grade: \_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other \_\_\_\_\_  
Child's primary language: \_\_\_\_\_ Home Language(s): \_\_\_\_\_  
Language(s) in school: \_\_\_\_\_  
Does parent require an interpreter/translator?: Yes  No  Language \_\_\_\_\_

Current Placement/Services Information:

Current School: \_\_\_\_\_ Current IEP Date: \_\_\_\_\_  
Current teacher: \_\_\_\_\_ Last assessment Date: \_\_\_\_\_  
Room \_\_\_\_ School hours \_\_\_\_\_ Track \_\_\_\_ Next assessment Date: \_\_\_\_\_  
Handicapping Conditions: \_\_\_\_\_  
Developmental/Cognitive Range:  
\_\_\_\_\_  
\_\_\_\_\_

Current academic levels: Reading \_\_\_\_\_ Math \_\_\_\_\_ Written language \_\_\_\_\_

PROGRAM SUPPORTS: Please UNDERLINE all that apply:

MEDICAL/MOTOR: Wheelchair Walker G-Tube Special Diet Diapers Tracheostomy Oxygen  
Catheterization MOVE program

COMMUNICATION: Augmented Communication Switches/devices Assistive technology

VISION: Glasses CCTV Scribe services Large print material Braille material Other \_\_\_\_\_

HEARING: Hearing Aid/s FM unit

OTHER: \_\_\_\_\_

CURRENT PROGRAMS AND SERVICES: (please UNDERLINE all that apply):

PLACEMENT: General Education

RSP

SDC (type) \_\_\_\_\_

DIS SERVICES:

Language and Speech

Adaptive PE

Occupational Therapy (circle whether provided by CCS or district)

Physical Therapy (circle whether provided by CCS or district)

Visually Impaired Itinerant Teacher

Orientation and Mobility Visually Impaired Itinerant Teacher

Orthopedically Impaired Itinerant Teacher

Deaf and Hard of Hearing Itinerant Teacher

Deaf/Hard of Hearing Interpreter or Translator

Psychological Counseling

Special circumstances paraeducator- Describe: \_\_\_\_\_

Other: \_\_\_\_\_

SPECIALIZED PLANS:

Behavior Plan

Health Plan

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

SIGNATURES:

\_\_\_\_\_  
Site Administrator

\_\_\_\_\_  
District Administrator/Designee Title: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Authorization for this for referral and Release of Student's Records to the Regional Service Provider:

\_\_\_\_\_  
Signature of Parent/Guardian Date: \_\_\_\_\_

Distribution: copy 1 – referring teacher copy 2 – Regional Service Provider/District Office copy 3 – school nurse

C:\My Documents\Low Incidence\Forms from Karen Wurfel\Referral for Reg. Serv.version2.doc/REVISED 1-17-03

## Evaluation to Determine the Need for Additional Support (1)

**Student:** \_\_\_\_\_ **School:** \_\_\_\_\_

**Teacher:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please complete the following review of the visual and physical structure of the classroom, curriculum design, data collection and planning.*

### A. Posted Schedule

1. The following are included in the posted schedule (attach sample).

Time       Student       Staff name       Activity

### B. Visual Schedule for Individual Student

1. Student uses the following as a symbol for individualized schedule:

Object       Photograph       Picture       Icon       Words

2. Room is arranged with a visual structure to show where tasks are completed per schedule:

Area for work one-to-one       Area for group work  
 Area for independent work       Area for leisure

3. Level of student following the schedule:

Independent       Indirect verbal or gesture prompt       Direct verbal prompt  
 Physical prompt       Not at all

4. Student use of schedule:

Student carries schedule       Student goes to schedule board  
 Student uses transition cards       Teacher carries and shows the schedule

### C. Curriculum and Instructional Planning

1. Check the curricular domains included in student program:

Communication       Pre-vocational/Vocational  
 Self-care       Behavior  
 Functional academics       Other  
 Motor skills/Mobility

2. Describe reinforcers and reinforcement schedule used.

3. List equipment or devices used that may relate to the need for assistance (may be low incidence equipment or assistive technology device).

4. List age appropriate materials and activities.

5. Describe an activity with the student and attach a sample task analysis form used for that activity if appropriate (see appendix for samples).

**D. Behavior Management**

1. Is there a current goal addressing the behavior(s) in the IEP?  Yes  No
2. Is there a behavior plan in place?  Yes  No
3. Attach a copy of documentation indicating frequency, severity and duration over a period of time (see sample data collection forms in appendix.)

**E. Current Data Systems and Collection of Data**

1. Is there current data on each IEP objective/benchmark (attach samples or use samples provided) that include:
- Date  Task  Level of independence
2. How often are data collected?
- Daily  Weekly  Bi-Weekly  
 Monthly  Other \_\_\_\_\_
3. How are data summarized (attach sample)?
- Graphed  Written narrative  Other \_\_\_\_\_

**F. On-Going Classroom Team Meetings**

1. How often are team meetings held (formal or informal meetings)?
- Daily  Weekly  Bi-Weekly  
 Monthly  Other \_\_\_\_\_
2. Attach team meeting format (see appendix for samples).

**G. Classroom Environment (Physical Structure)**

- Diagram the arrangement of furniture and small group instruction areas and equipment that provides the physical structure of the classroom (see attached sample).

**H. Describe the school day, assistance now provided, and the assistance needed.**

**I. Check which other types of assistance have been provided as well as which are currently being requested.**

	<u>Already Provided</u>	<u>Being Requested</u>
Training for instructional staff	<input type="checkbox"/>	<input type="checkbox"/>
Consultation for the classroom	<input type="checkbox"/>	<input type="checkbox"/>
In-classroom coaching	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

## Evaluation to Determine the Need for Additional Support (2)

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

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

*Check the areas of intensive need that might indicate the need for additional instructional assistance or support.*

Health/Personal Care	Behavior	Instruction	Inclusion/Mainstream
<input type="checkbox"/> Specialized health plan <input type="checkbox"/> G-tube <input type="checkbox"/> Medications <input type="checkbox"/> Suctioning <input type="checkbox"/> Food preparation <input type="checkbox"/> Diaper changing <input type="checkbox"/> Feeding (full support) <input type="checkbox"/> Seizures weekly + <input type="checkbox"/> Lifting/Transfers <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Behavior plan in place <input type="checkbox"/> Physically aggressive weekly+ <input type="checkbox"/> Non-compliant in class <input type="checkbox"/> Non-compliant on campus <input type="checkbox"/> Runs away weekly+ <input type="checkbox"/> ADHD medicated <input type="checkbox"/> Mental health client <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Discrete Trials/ABA <input type="checkbox"/> Physical prompts 80%+ <input type="checkbox"/> Verbal prompts 80%+ <input type="checkbox"/> Structured teaching <input type="checkbox"/> Assistive technology <input type="checkbox"/> PECS <input type="checkbox"/> Signing 80%+ <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Direct adult instruction <input type="checkbox"/> Physical support/positioning <input type="checkbox"/> Safety supervision 80%+ <input type="checkbox"/> Close visual supervision 80%+ <input type="checkbox"/> Other: _____ _____

*Describe EACH area of intensive need marked above and indicate if there is an IEP goal/objective written to address the area. Use additional paper if needed to describe all the needs.*

*Describe interventions used to support referred student in EACH of the areas marked above. Provide data that documents the prior success or failure of interventions and complete attached school day description and assistance needed.*