NKCES

2015 – 2016 Request for Services /Referral Form

School District:	**School:**
School Contact Person:	**Phone:**
Title:	**Best Time to Contact:**

TYPE OF SERVICE REQUESTED:

TRAINING	**CONSULTATION** ○ **STAFF** ○ **CLASSROOM**	**DIRECT REFERRAL** **Student's Name _____** **DOB _____** **Grade _____**

SERVICES REQUESTED

(Please check services requested and complete page 2 of this form)

PBIS ○ Training ○ Consultation	Assistive Technology ○ Training ○ Consultation ○ Evaluation: Completed AT referral form, current IEP, & permission to evaluate **must be** provided.
Due Process ○ Training ○ Consultation	Collaboration/Differentiation/Co-Teaching ○ Training ○ Consultation
Low Incidence ○ Training ○ Consultation	Literacy ○ Training ○ Consultation
Outreach Services ○ KY School for the Blind ○ KY School for the Deaf ○ KY Deaf-Blind Project	Transition ○ Training ○ Consultation
○ This request is ☐ or ☐ is not a result of a Corrective Action Plan submitted to KDE or OCR.	Services from Other Agencies ○ Children's Hospital Division of Developmental & Behavioral Pediatrics Evaluation ○ Complex Needs Observation/Consult ○ Evaluation through the Kelly O'Leary Center For Autism Spectrum Disorders ○ Psychiatric Evaluation ○ Other
	This request is ☐ or ☐ is not a result of a need identified during district school improvement.

Who needs to follow-up to ensure implementation?

NKSEC STAFF ☐ DOSE ☐ SCHOOL PRINCIPAL ☐ OUTREACH STAFF ☐ OTHER ☐

Complete This Section for Training and Consultation Requests:

Topic/Issue:	
Goal: What should participants know or be able to do as a result of the consultation training?	
Anticipated Target Audience:	
Projected number of participants:	
Requested date(s)/Time/Location:	

Assurance: I understand in making a request for training that the special education staff will participate and the training will have an impact on outcomes for special education students. I also understand that the funding for this training is targeted to those students receiving specially designed instruction within the setting defined by the Individual Education Plan.

Director of Special Education /or Principal Signature: _____Date: _____
Note: A typed name will be accepted if form is submitted by DoSE/Principal via email)

Parent Permission Required for Referral to Outside Agencies Only (not for NKCES staff)
This is to indicate that I have been informed and counseled regarding the referral of my child for individual services (checked above) as determined by personnel of the school district named and in cooperation with the Northern Kentucky Cooperative for Educational Services (NKCES).

I give my permission for such services, consent for Director or designee from referring school district to attend informing interview, and release of related reports to NKCES and the referring school district.
I will make every effort to keep all scheduled appointments.

Parent Signature: _____ *Date: _____
*** Parent permission is valid for one (1) year after date signed.**

Director of Special Education: _____ Date: _____

E-mail completed Request for Services form to penny.day@nkces.org or fax to 859-442-7038 Attention: Penny Day

FOR NKCES OFFICE USE ONLY:

DATE Received: _____

Request Accepted: ☐ **Yes**
☐ **Yes – pending further information: _____**
☐ **No – Reason: _____**

Assigned PL Coach: _____

Date of First Contact by PL Coach: _____