Do not alter Essex County Forms. They have been designed to meet State and Federal requirements.

DEPARTMENT
Children's Services Unit

Initial Referral
Committee on Preschool Special Education

ESSEX COUNTY

Referral Date:

Child:_____ School District:_____ Foster Child:☐
First, Middle Name Last

DOB:_____ Age:_____ Sex:_____ Native Language:_____ Racial/Ethnic Category:_____

Parent /Guardian:_____ Parent / Guardian:_____

Relationship to child:_____ Relationship to Child:_____

Address:_____ Address:_____

_____ _____

Phone: (Home):_____ Phone: (Home):_____
Phone: (Work):_____ Phone: (Work):_____

Emergency Contact Information
Name:_____ Phone:_____ Relationship to Child:_____

Person Making Referral Information
Name:_____ Phone:_____ Relationship to Child:_____
Address:_____City:_____ **NY** Zip:_____

Physician Information
Name: _____ Phone:_____

Address:_____City:_____**NY** Zip:_____

Significant health issues/medical alerts:

Current Program/Services:_____ Site:_____

☐	SEIT	Provider:_____	Frequency/Duration_____
☐	OT	Provider:_____	Frequency/Duration_____
☐	PT	Provider:_____	Frequency/Duration_____
☐	Speech	Provider:_____	Frequency/Duration_____
☐	other	Provider:_____	Frequency/Duration_____

Reason for referral (describe in detail):

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MANDATED COMPONENTS

☐ Psychological
☐ Social/history
☐ Physical
☐ Observation of child in educational and/or natural environment

ADDITIONAL ASSESSMENTS

☐ PT
☐ OT
☐ Speech
☐ Audiological
☐ Functional Behavioral Assessment
☐ Other:_____

CPSE Chairperson's Signature:_____ Date Received:_____