Revised 11/06
Form D-Gray

Date Received

REEVALUATION REFERRAL FORM

Prior Verification Date: _____
Current Verification:_____
New to District _____ Yes _____ No
Prior District: _____

Exit/MDT High School _____
Exit/MDT Completion of H.S. Program_____

Services currently receiving: ☐ Resource ☐ Sp/Language ☐ Chapter I ☐

Other: PT/OT, Counseling, etc. _____

Student Information:

Name (Last, First, Middle Initial)	D.O.B.	Sex	Grade

Name (Legal Parent/Guardian)	Telephone # (home)	Telephone # (cell)

School District	Contact Person	Telephone #

Reevaluations require that past evaluation data be reviewed by individuals trained to interpret assessment data in each respective area. Please refer to the most recent MDT verification form for this student to determine what disciplines (i.e. psychologist, speech/language pathologist, vision consultant, hearing consultant, etc.) need to be involved.

We request that the following ESU #7 professionals participate in a school district review of existing evaluation data on the child. The reevaluation committee will decide whether or not additional data, if any, are needed to determine if the child continues to have a disability.

☐ School Psychologist
☐ Speech/Language Pathologist
☐ Consultant for the Visually Impaired
☐ Consultant for the Hearing Impaired
☐ Occupational Therapist
☐ Physical Therapist
☐ Other _____
_____

Date Administrator Notified:_____

Reset Form