Early Childhood Special Education Referral

(Birth until kindergarten enrollment)

Person completing referral:
Name:_____

Title:_____

Phone:_____

Are parents aware of this referral? ☐ Yes ☐ No

(Please complete as much information as you are able to)

Child's Full Name:_____

Date of Birth: _____

Age Range: ☐ Birth to 2 years 10 months 16 days

☐ 2 years 10 months 17 days to 5 years old

Gender: ☐ Female ☐ Male

Parent/Guardian: _____

Role: *(i.e. Mother, Father, Foster Parent, etc.)* _____

Phone: _____

Email: _____

Parent/Guardian: _____

Role: *(i.e. Mother, Father, Foster Parent, etc.)* _____

Phone: _____

Email: _____

Child's Primary Residence is with ☐ Mother ☐ Father ☐ Both Parents ☐ Other_____

Home Address: _____

What are your questions/concerns?

☐ Fine Motor	☐ Communication/Speech
☐ Gross Motor	☐ Social/Emotional/Behavior/Social
☐ Cognitive	☐ Health/Physical
☐ Speech/Language	☐ Sensory concern: Vision
☐ Functional/Adaptive	☐ Sensory concern: Hearing
☐ Low Birth Weight	☐ Child abuse/neglect

Where does the child receive primary care? Primary Physician?

Does the child have any diagnosed conditions?

Is there any other relevant information we should be made aware of?

Fax: 507-494-0932 *(Attention: ECSE SE Coordinator; Angie Lepsch)*
Call: 507-494-0842 Email: ecfereferrals@winona.k12.mn.us