Dearborn STEP
Assessment Program
REFERRAL FORM
2024-2025
575 Washington Street
Newton, MA 02458
2024-2025

STEP phone: 781-641-3743
Email: smcginn@dearbornstep.org

Date of Referral: ___________________________

Student Information

Student Name:

DOB:

Age:

Current Grade:

Pronouns:

Current school:

Student Medical Conditions/Needs (include medications, allergies, physical limitations, chronic illnesses):

Caregiver Information

Name of Caregiver(s):

Relationship to student:

Address:

Phone Number (s):

Email:

Name of Caregiver(s):

Relationship to student:

Address:

Phone Number (s):

Email:

Primary Language spoken in home:

If English is not the primary language, is a translator needed to support caregivers?

District/Sending School System:

Name of person completing form/title:

School District:

Special Education Director:

District contact person for this student:

District contact person phone number:

Contact Email:

Billing Contact Person:

Billing Contact email:

District Questions

Reason for STEP Referral: Please describe what prompted the STEP referral as well as your goals of the assessment.

What are your primary goals for the assessment?

<u>Current Educational Program provided by district</u>:

Is the student on an IEP? Yes _____ No _____

Is the student on a 504 plan? Yes _____ No _____

<u>Academics</u>

What MCAS has been PASSED?

Academic Strengths**:**

Academic Challenges:

***During our assessment, STEP will complete the **Kaufman Test of Educational Achievement Third Edition**

Has Academic testing been done in the past year?

Yes ____ No _____

<u>*Necessary Contact Information for STEP</u>

<u>Name and Email of Academic Contact</u> (who would provide academic work if credits and/or staying in line with district curriculum is a priority).

Name: _____________________________

Email Address: ______________________

If you prefer that STEP provides work as a means of assessment, please indicate if that is your preference and if there are any conditions related to this (ie. grading)

<u>Name and Email of Clinical Contact</u>

Name: _____________________________

Email Address: ______________________

For midpoint and final meeting for this student, which district staff will be present in the meeting?

Name: ___________________________

Name: ___________________________

List Current Providers (therapists, psychiatrists & agency involvement, etc.)

Name(s):	**Position/Title:**
_________________________________	___________________________
_________________________________	___________________________
_________________________________	___________________________
_________________________________	___________________________

Please send and attach prior/recent testing & evaluations, incident reports, discipline/conduct records, IEP or 504