Dr. Donald W. Martin
Executive Director

Intermediate Unit 1

Serving Fayette, Greene, and Washington Counties

One Intermediate Unit Drive | Coal Center, PA | 15423
Phone: 724.938.3241 | Fax: 724.938.6665
www.iu1.org

REFERRAL FOR SUPPORT SERVICES

Service(s) Requested:

- ☐ Auditory Processing (requires normal hearing)

Hearing:

- ☐ Audiologic Evaluation
- ☐ Hearing Assistive Technology (FM System)
- ☐ Hearing Support Services (Teacher of Deaf/HH)

- ☐ Occupational Therapy*
- ☐ Physical Therapy*
- ☐ Psychiatric
- ☐ Social History
- ☐ Speech/Language

Vision:

- ☐ Vision Assistive Technology
- ☐ Vision Support Services (Teacher of Vision)
- ☐ Vision Support Services (O & M)

- ☐ Other: Specify _____

Referral Source(s):

- ☐ Pre-referral Screening
- ☐ Consultation (specify for which service(s), if more than one selected): _____
- ☐ Initial Referral (Permission to Evaluate) ER Due Date: _____
- ☐ Reevaluation (Permission to Reevaluate) RR Due Date: _____
- ☐ Transfer Student Previous District/State: _____
- ☐ Chapter 16

Student Specific Information:

Student Name: _____ DOB: _____ Grade: _____
Ethnicity: _____ Gender: _____
Parent/Guardian: _____
Mailing Address: _____
Parent/Guardian Phone: _____ (H) _____ (C) _____ (W)
PA Secure ID: _____ School District of Residence _____
School Attending: _____ School Phone: _____
Contact Person/Role: _____ Phone: _____
Contact Person e-mail address: _____
Teacher: _____ Teacher e-mail: _____

_____ _____
***LEA SIGNATURE (REQUIRED)** **DATE**

To be completed by IU1 Department Supervisor:

APPROVED BY: _____ _____
IU1 SUPERVISOR'S SIGNATURE DATE

ASSIGNED TO: _____ _____
SUPPORT STAFF NAME DATE

_____ _____
SUPPORT STAFF NAME DATE

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