Sample Referral Form

Return this completed form to the school 504 Coordinator/Problem Solving Team (PST)

Student's Name ________________________________ Age _____ DOB ___/___/______

Grade _______ Homeroom Teacher ________________________________

Person Initiating Referral _______________________ Position __________________________

Please answer the following questions:

1. Reason for referral.
   ________________________________________________________________________________
   ________________________________________________________________________________

2. Which of the following major life activities do you believe is limited?
   (Check ALL that apply.)
   ☐ Performing Manual Tasks ☐ Motor ☐ Reading
   ☐ Walking ☐ Breathing ☐ Concentration
   ☐ Seeing ☐ Learning ☐ Thinking/Comprehension
   ☐ Hearing ☐ Balance/Coordination Communicating
   ☐ Speaking ☐ Strength ☐ Other ______________

3. Describe the student's physical or mental impairments(s).
   ________________________________________________________________________________

4. Describe interventions/strategies used to address difficulties.
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

_________________________________________ ________________________________
Signature                                      Date

_________________________________________ ________________________________
Date received by school                         Received by