UF UNIVERSITY of FLORIDA

Multidisciplinary Diagnostic and Training Program (MDTP)
Evaluation•Instruction•Consultation•Research

1699 SW 16th Avenue
Gainesville, FL 32608-1158
352-294-8248
352-627-4507 Fax

SCHOOL/DISTRICT REFERRAL FORM
Please fax completed form (352) 627-4507

Today's Date: _____

Referring School/District Information

Person Completing This Form (Name & Title):_____

District: _____ School: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel. No(s): **( )** _____-_____ **Ext.:** _____ **; ( )** _____-_____

Fax No: **( )** _____-_____

Student Information (*Required, Please Provide)

*Last Name: _____ * First Name: _____ Gender: M / F

*DOB: ____/____/_____ School: _____ Grade: _____

*Parent/Legal Guardian's Name: _____

*Mailing Address: _____ *City: _____ State:___ *Zip: _____

*Phone No: Home ( ) _____-_____ Work ( ) _____-_____ Mobile ( ) _____-_____

** [Please verify that the **contact information** provided above for the family is **current and correct.**]*

Concerns Prompting Referral/Consultation Request

Please check any/all that apply

___ poor academic progress/grade retention
___ learning difficulties unresponsive to educational interventions
___ chronic/other health condition impacting school functioning/participation
___behavioral problems impacting academic progress/school functioning/peer interactions
___ language/learning problems associated with poor academic progress/socioemotional problems
___ other (please describe): _____
_____

Does the student have a Progress Monitoring Plan (PMP)/Academic Improvement Plan (AIP)? *Circle one:* No Yes
Does student have an Individual Educational Plan (IEP)? *Circle one:* No Yes
Does the student have a Section 504 Accommodation Plan? *Circle one:* No Yes
Does the student receive speech, language, occupational, or physical therapy? *Circle one:* No Yes

Prior evaluations *(please check any/all that apply):* ( )Speech ( )Language ( )Psychoeducational/Psychological ( )FDLRS Child Find ( )Neuropsychological ( )Other:_____

Current therapies (p*lease check any/all that apply):* ( )Speech/Language ( )Occupational/Physical Therapy ( ) Psychological/Mental Health ( )Family Therapy ( )Other:_____

Primary Care Doctor: _____ Insurance Provider: _____

Thank you. Please call (352) 294-8248 with any questions.