Northwest Regional ESD
5825 NE Ray Circle
Hillsboro, OR 97124
Phone: 503-614-1470 | Fax: 503-614-1285

eMail Form | Print Form | Reset Form

Referral Date: _____
Interpreter Needed: _____
Language: _____

Request for Contracted AC/AT Services

REQUESTED SERVICE: EVALUATION

Enter requested hours

☐ Evaluation (submit immediately once consent is signed)	**Up to 15 hours**	
	TOTAL HOURS REQUESTED	

CONTACT INFORMATION	
Case Manager Name/ Title / Teacher:	
Case Manager eMail:	Case Manager Phone Number:
Speech Language Pathologist (AAC):	Occupational Therapist (AT):
Speech Language Pathologist Phone Number:	Occupational Therapist Phone Number:
Speech Language Pathologist eMail:	Occupational Therapist eMail:

Required Attachments for Evaluation:	**Return completed form via courier, fax, or eMail to:**
☐ **AAC Referrals** - Completed AAC Checklist	NWRESD Attention: AC/AT Program 5825 NE Ray Circle, Hillsboro, OR 97124 Phone: 503-614-1470 | Fax: 503-614-1285 eMail: acatreferrals@nwresd.k12.or.us
☐ **AT Referrals** - Completed AT Checklist	
☐ **Evaluation Consent Form / Current IEP**	
☐ **Pre-Referral intervention data (recommended)**	

STUDENT INFORMATION FOR INDIVIDUAL ASSESSMENT					
Student Last Name:		Student First Name:		MI	Sex:
Student's SSID:	Student's Grade:	District:		School:	
Parent/Guardian Name(s)		Primary Phone:		Work Phone:	
Mailing Address:		City:	State:	Zip Code:	
Current IDEA Eligibilities:	Current IEP: ☐ Yes	☐ No	Current IEP Date:		
Student – Regionally Eligible	☐ Yes	☐ No			

_____ _____

School District Administrator Signature *Date*

NWRESD OFFICE USE ONLY

_____ _____ _____

Date Referral Received *Date Assigned* *Assigned To*

Check Applicable: Funding: ☐ | Existing hours: ☐ | Link to Form 30