BEMIDJI REGIONAL INTERDISTRICT COUNCIL

Request for Consultation

Referral Information			
Date:		District:	
Referred by:		Completed by:	
Requesting:	☐ Teacher Consult → (Parent Contact Not Required)	Method of Parent Contact:	
Requesting:	☐ Student Consult → (Parent Contact Required)	Date of Parent Contact:	

Learner Information				
Full Name:			Date of Birth:	
Grade:			Teacher:	
Parent/Guardian:				
Address:				
Home Phone:			Work Phone:	
Current IEP/IFSP:	☐ Yes	☐ No	If yes, Disability:	

If there are any scheduling concerns or limitations for this student, please list them below (i.e., attending partial days, need for specific time or day for 0 – 5 year olds, need for observation to be conducted during a specific class period, etc.)

Are there attendance concerns? If yes, please describe below. ☐ Yes ☐ No

Areas of Concern			
☐	Sensory Integration / Occupational Therapy	☐	Vision (Attach vision screening results or ophthalmological report)
☐	DAPE	☐	Assistive Technology
☐	Hearing (Attach hearing screening results or previous audiogram)	☐	Functional
☐	Physical Therapy	☐	Health/Physical
☐	Behavior	☐	ASD

Include a description of the concerns including any interventions already attempted, for each checked area; or attach a document.

Send a copy of this form to your BRIC Supervisor

OFFICE USE ONLY					
Date Received:		Consultant(s) Assigned:		Date of Consult:	
Supervisor Signature:			Director Signature:		
Notes:					