

# The Vista School<sup>®</sup>

## School District Referral

### Referral Information

Instructions: Please fill out this document to the best of your ability. Include copies of relevant information where noted. **Incomplete referrals will NOT be processed until all requested information is received.**

#### Documentation of diagnosis

1. Most recent *School Evaluation Report, Psychological and Psychiatric reports within the last two years,*
2. Child's last two *IEPs, Behavior Plans (FBAs), and Graphs* as well as any other relevant information to ascertain student's progress over the last year,
3. Most recent *IEP Progress Report* with at least two quarters of progress,
4. Child's last two *Treatment Plans,*
5. Information from outside sources such as *Speech-Language Pathologist (SLP), Occupational Therapist (OT), Psychologist, etc.*
6. Completed *Autism Insurance Act Questionnaire* and copy (front and back) of Child's *Private Insurance Card,* verification (printout or copy of MA card) of Medical Assistance eligibility,
7. School District information and approving signature with contact information

PLEASE NOTE: If you are submitting the packet as a parent referral (i.e. no district involvement), please include a completed scholarship application with tax information attached. This information is required for private pay cases as well.

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## School District Referral Information Form

Date: \_\_\_\_\_ Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ Sex: \_\_\_\_\_

Student's Medical Assistance Number (10-digit): \_\_\_\_\_ Race: \_\_\_\_\_

**Please attach a copy of child's Medical Assistance Card and Private Insurance Card to referral packet.**

Family Contact Person(s): (1) \_\_\_\_\_ (2) \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ E-mail: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

Number of adults in household: \_\_\_\_\_ Names: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Number of children in household: \_\_\_\_\_ Names: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

School District: \_\_\_\_\_ IU: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Clinical diagnosis: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Child's age at diagnosis: \_\_\_\_\_ Performed by: \_\_\_\_\_

Does the student have a secondary diagnosis and/or other medical conditions? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Is the student currently enrolled in a school/program? \_\_\_\_\_ If yes...

Name of school/program: \_\_\_\_\_

School district: \_\_\_\_\_

Special Education Director: \_\_\_\_\_

Program Description: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# The Vista School ®

Is the student on medication? \_\_\_\_\_

If yes, list medication, dosage, administration times and what medication is used for.

Name of Medication	Dosage	Administration Times	Used for...

Has the student ever been admitted to a hospital/treatment center for a psychiatric, behavioral or crisis situation? \_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Please summarize the hospital/treatment facility's observations and treatment(s): \_\_\_\_\_

\_\_\_\_\_

Was this treatment effective? \_\_\_\_\_ Please explain: \_\_\_\_\_

\_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

(School District Representative)

**Completion and submission of the referral form to The Vista School's admissions team begins The Vista School screening process. Further, it provides a forum for parents' and school districts' consideration of Vista as part of a continuum of appropriate placement options. Referrals are non-binding to Vista and school districts. The submission of a referral form does not guarantee acceptance or enrollment into Vista's programs.**