CANYONS SCHOOL DISTRICT
A DECADE OF EDUCATIONAL EXCELLENCE
10 YEARS

Multilingual Student Consultation Request for Special Education Evaluation

Date:	School:	
Parent Notified of Concerns (Date)	Notified by:	
School Contact:	Contact Phone:	
Student Name:	Student #	Grade:
WIDA Level:	Teacher/Counselor	

Reason for Referral		**Referral Comments and Notes:**
Academics		
ELA Only		
Math Only		
Behavior		
Speech/Language		

Required documentation for referral consideration. Please submit with this referral request.

	Completed			
Parent Interview		Yes	No	Date:
Hearing Assessment		Pass	Fail	Date:
Vision Assessment		Pass	Fail	Date:
If No or Fail to any of the above, please explain circumstance and describe follow-up:				

Intervention Implemented	**Duration and Frequency**	**Expected Performance Level**	**Student performance level post-intervention**
Key vocabulary pre-taught with visuals in small group instruction.	*20 minutes 2X per week 4 weeks*	*Student will use 4 out of 5 key vocabulary terms correctly on weekly assessments.*	*Student used 2 out of 5*

Other Supporting Data/Evidence: i.e. Acadience, DWSBA, CFA, RI, CICO , Tracker data

Email this form and documentation to: ML_Evalteam@canyonsdistrict.org