



THE MAINE EDUCATIONAL CENTER FOR THE DEAF AND HARD OF HEARING
GOVERNOR BAXTER SCHOOL FOR THE DEAF

One Mackworth Island, Falmouth, ME 04105
 207.781.6230
 www.mecdhh.org

STATEWIDE EDUCATION SERVICE REQUEST

Date of Request: _____

<input type="checkbox"/> Site-based program: (check desired location; <u>not</u> a guarantee of placement)					<input type="checkbox"/> Outreach services: (Itinerant services within home school district)
<input type="checkbox"/> Mackworth Island Pre-School	<input type="checkbox"/> East End Community School	<input type="checkbox"/> Lyman Moore MS	<input type="checkbox"/> Portland HS	<input type="checkbox"/> Brewer Community School	
Educational plan type: Check one if known					
<input type="checkbox"/> Individual Education Plan IEP	<input type="checkbox"/> 504 Accommodation Plan	<input type="checkbox"/> Regular Education	<input type="checkbox"/> Individual Service Plan ISP (incl. homeschool)		

Student Name:	Date of Birth:
School Dist./City:	School Name:
IEP/504 Date (if applicable):	Re-Evaluation Date (if applicable):
Referring individual name, role, contact ***email, phone:	

Service requested:

Provider Type	Service	Additional details	Frequency/Intensity
Choose from: <ul style="list-style-type: none"> • Audiologist • Interpreter/Transliterator • Occupational Therapist • Physical Therapist • Psychologist (site-based only) • Social Worker • Speech Language Pathologist • Teacher: Deaf/Hard of Hearing • Teacher: Special Ed. 	Choose from: <ul style="list-style-type: none"> • Consultation • Direct Service/SDI or therapy • Evaluation • IEP/504/ISP Meeting • Observation • Parent Training and Counseling 	Fill-In Add any other pertinent information <ul style="list-style-type: none"> • Communication Mode • ASL/Cue or LSL support • Schedule limitations • Concerns • Other 	Fill-in whether service is: <ul style="list-style-type: none"> • One time initial consult/ observation/ meeting, • ESY / Academic year • Ongoing: please include plan specified <ul style="list-style-type: none"> ○ Frequency (repeated over what time frame) ○ Intensity (time/session)
Provider Type	Service	Additional details	Freq./ Intensity

Reason for Referral and Relevant Information:

To facilitate processing, please attach the following:

- Student Information Form (completed by home or school)
- Copy of current IEP, 504, ISP, and recent Written Notice (as appropriate)
- Signed consent to Evaluate – if applicable
- Signed authorization to release and share information with school district
- Signed authorization to release and share information with treating audiologist

Please send all referrals and documentation to: referrals@mecdhh.org

For more information, contact :
Kimberly Spencer
referrals@mecdhh.org
207-781-6230

For MECDHH Office Only: DATE ASSIGNED: _____

<input type="checkbox"/> MECDHH accepts this referral in total.	<input type="checkbox"/> MECDHH accepts this referral in part (see signatures below)	<input type="checkbox"/> MECDHH declines this referral in total. Reason for declining:
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Status of Referral:

Assigned to and Role:	* Provider Signature:	Signed Date:	Start Date (if known):

*The parties agree that the electronic signature of a party to this Agreement shall be as valid as an original signature of such party and shall be effective to bind such party to this Agreement.