**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**: _____

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

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|---|---|
| **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:<br>• Audiologist<br>• Interpreter/Transliterator<br>• Occupational Therapist<br>• Physical Therapist<br>• Psychologist (site-based only)<br>• Social Worker<br>• Speech Language Pathologist<br>• Teacher: Deaf/Hard of Hearing<br>• Teacher: Special Ed. | Choose from:<br>• Consultation<br>• Direct Service/SDI or therapy<br>• Evaluation<br>• IEP/504/ISP Meeting<br>• Observation<br>• Parent Training and Counseling | Fill-In Add any other pertinent information<br><br>• Communication Mode<br>• ASL/Cue or LSL support<br>• Schedule limitations<br>• Concerns<br>• Other | Fill-in whether service is:<br>• One time initial consult/ observation/ meeting,<br>• ESY / Academic year<br>• Ongoing: please include plan specified<br>○ Frequency (repeated over what time frame)<br>○ Intensity (time/session) |

| **Provider Type** | **Service** | **Additional details** | **Freq./ Intensity** |
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| **Reason for Referral and Relevant Information:** |
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**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** |
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| **For more information, contact our referral administrative assistant:**<br>**Kimberly Spencer**<br>**referalls@mecdhh.org**<br>**207-781-6230** |

**For MECDHH Office Only: DATE ASSIGNED: _____**

| ☐ MECDHH accepts this referral in total. | ☐ MECDHH accepts this referral in part (see signatures below) | ☐ MECDHH declines this referral in total. Reason for declining: |
|---|---|---|
| | | |

**Status of Referral:**

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