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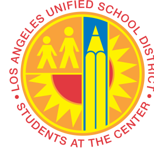

LOS ANGELES UNIFIED SCHOOL DISTRICT
ADMINISTRATIVE OFFICES

DIVISION OF SPECIAL EDUCATION
333 South Beaudry Avenue, 17th Floor
Los Angeles, California 90017
Telephone: (213) 241-6701
Fax: (213) 241-6842

DR. MARIBEL LUNA
Senior Director of Special Education

LOW INCIDENCE REFERRAL FORM

Child's Name ______________________ DOB __________ Gender __________

Parent/Guardian Name ______________________ Home Language __________

Address ______________________ City __________ Zip __________

Home Phone __________ Work Phone __________ Cell Phone __________

Referred By __________ Agency __________ Date of Referral __________

Phone # __________ Fax # __________ E-mail __________

Area of concern:

☐ **Hearing (DHH)** **Vision (VI)** ☐ **Severe Orthopedic (OI)**

Do not refer for the LAUSD orthopedic service program
- If child has or has been referred for CCS therapy
- If the child is or will receive regional center services

Reason for referral; brief description of concern: ______________________

____

Attached is a current report: ☐ IFSP ☐ Audiologist ☐ Ophthalmologist ☐ Optometrist ☐ Doctor

Is the child currently receiving services from Regional Center? ☐ No ☐ Yes: which services and frequency?

____

Who is the Service Coordinator? ______________________

If not, are there concerns that might warrant a referral to Regional Center? e.g. Developmental/motor/language concerns (not related to hearing, vision, or orthopedic delays). If so, please list your concerns.

E-mail this form to:
infantreferrals@lausd.net

(Or) Mail this form with reports to:
Early Childhood Special Education
333 S. Beaudry Avenue -
17th floor Los Angeles, CA 90017
Phone: (213) 241-4713

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