CSSU Career and Transition Services
Preliminary REFERRAL

School Year 20__- 20__

Student Information:

Name: _____

Street: _____

Town: _____ Zip: _____

Date of Birth: ___ / ___ / _____ Grade Next Year: _____

Parent / Guardians Names: _____

Home Phone: _____ Work Phone: _____

E-mail Contact: _____

Services Information... *Check box for YES*

- ❑ Previous Community Skills Participant? If *yes*, when? _____
- ❑ Receiving Special Ed. Services? Eligibility: _____ _
- ❑ Community-based vocational program required in current IEP?
- ❑ Receives outside agency support? What agency? _____
- ❑ Receives ESY Services?
- ❑ Transportation Supports in IEP?
- ❑ Requires 1:1 support in all settings?

Please check boxes to indicate the focus of our services:

- ❑ Work Experience or Job Training
- ❑ Career Explorers (CVU Class)
- ❑ Transition Skills and Self-Advocacy (CVU Class)
- ❑ Vocational or Transition Assessment
- ❑ Community Independence Activities
- ❑ Social Connections and Skills
- ❑ Recreational or Wellness Activities
- ❑ Post-secondary links

Other: _____

_____

Transition Services (age 16 and up)

Does the student have? Check for YES

- ❑ A Transition Plan that they participated in?
- ❑ Adult agency links that are actively included in planning?
- ❑ A post-secondary goal that was updated this year?
- ❑ IEP Goals related to the transition services needs?
- ❑ A recent age-appropriate transition assessment?
- ❑ A Transition Plan that will help the student achieve their goals?

Check any we can help address this year.

Case Management Information

When is an IEP meeting scheduled to discuss transition /vocational services?

Date: _____ Time: _____

Location: _____

Name of person making referral:

_____

Phone: _____

PLEASE ATTACH THE SECTION OF THE IEP WITH COMMUNITY OR VOCATIONAL GOALS