Lane Regional Inclusive Services
1200 Hwy 99 N
Eugene OR 97402
Ph: 541-461-8200 Fax: 541-461-8399

REFERRAL FOR SERVICES

DATE: _____

Student Name: _____ DOB: _____ Age: _____ Grade:

Attending School: _____ Resident District: _____

Parent(s) Names: _____

Parent Address: _____

Parent Phone: _____ Parent Phone: _____

Parent email: _____

IEP Date: _____ Eligibility Date: _____ Current Eligibilities: _____

Service Coordinator: _____ Phone: _____ email: _____

Person Making Referral: _____ Phone: _____ email: _____

Have parents been informed of this referral? ☐ YES ☐ NO

Other Agencies serving this child: _____

PLEASE ATTACH INFORMATION SPECIFIED BELOW. WITH EACH NEW REFERRAL SEND COPIES OF CURRENT IEP & ELIGIBILITY
COMPLETED PACKETS MAY BE EMAILED TO: LRISreferrals@lesd.k12.or.us

AUTISM	☐ Eligibility Statement
DEAF - HARD OF HEARING	☐ Medical/Physician's Statement documenting hearing loss (only if hearing loss is conductive) ☐ Audiological Report ☐ Copy of Exchange of Information ☐ Consent to Evaluate ☐ Eligibility Statement (if applicable)
ORTHOPEDIC IMPAIRMENT	☐ Eligibility Statement
TRAUMATIC BRAIN INJURY	☐ Copy of Exchange of Information ☐ Consent to Evaluate ☐ Eligibility Statement (if applicable)
VISUALLY IMPAIRED	☐ Copy of Exchange of Information ☐ Consent to Evaluate ☐ Eligibility Statement (if applicable Statement from an Ophthalmologist or Optometrist) ☐ Consent to Evaluate

Issues of Concern:

_____

Signature of Principal or District Program Referral Coordinator

LANE REGIONAL PROGRAM

1200 Highway 99 North
Eugene, Oregon 97402-2033
(541) 461-8200 Fax (541) 461-8298

Medical Statement or Health Assessment Statement

Please return to: _____
_____
_____

Child's Name: _____
Date: _____
Birthdate: _____

To the physician or health practitioner: The above-named child has been referred for an evaluation to determine eligibility for special education services. Oregon law requires that a medical statement or health assessment be obtained for certain categories of disabilities. This medical statement will be used by the educational evaluation team to assist in determining eligibility for special education services.

The areas of concern to the program are checked below. Please assist us by answering each question by a check in the first box of the row.

Note: Please answer the questions(s) in the area(s) checked below.			
☐	☐ No	☐ Yes	1. The child has a vision problem. If yes, check each of the following that apply: ☐ The child's visual acuity is 20/70 or less in the better eye with correction. ☐ The child's visual field is restricted to twenty degrees or less in the better eye. ☐ The child has either an eye pathology or progressive eye disease that is expected to reduce acuity of field to one of the above criteria. ☐ The child cannot be tested but demonstrates inadequate functional vision. Comments:
☐	☐ No	☐ Yes	2. The child has a hearing problem. If so, complete the following: ☐ The child has a sensory-neural hearing loss. ☐ The child has a conductive hearing loss that ☐ is ☐ is not treatable. The use of amplification ☐ is ☐ is not appropriate. Comments:
☐	☐ No	☐ Yes	3. The child has a voice disorder. Comments:
☐	☐ No	☐ Yes	4. There are physical factors that contribute to a speech or language problem Comments:
☐	☐ No	☐ Yes	5. The child has a ☐ health impairment ☐orthopedic impairment ☐ motor impairment that is permanent or expected to last more than 60 days. If yes, please provide a diagnosis or description of the impairment:
☐	☐ No	☐ Yes	6. The child has an acquired injury to the brain, caused by an external physical force that is expected to last at least 60 days. If yes, please provide a diagnosis or description of the impairment:
☐	☐ No	☐ Yes	7. There are physical or sensory factors that may affect the child's educational performance. If yes, please describe:

Physician's Signature/Title _____ Date: _____

Print Name: _____

LANE REGIONAL PROGRAM

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Parent Consent for Confidential Information Exchange

I give my permission to the Lane Regional Program to exchange confidential information concerning:

_____	_____	_____
Full name of student	Birthdate	Current school and grade

Agency or individual	**Address**	**Information to be exchanged**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please send information to the address checked below:
Requested by: _____
Name

_____

_____

_____

I understand that this information will not be shared with agencies or individuals other than those indicated, and that this permission is only valid for one year from the date of my signature. I further understand that my consent is voluntary and may be revoked at any time.

_____	_____	_____
Signature	Relationship to student	Date

Lane Education Service District , 1200 Hwy 99 N, Eugene, OR 97402, 541-461-8251 / Fax 541-461-8399

Authorization to Use and/or Disclose Educational and Protected Health Information

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

_____ (Student/Child's Name)

_____ (Date of Birth)

_____ (Other Names Used by Student/Child)

_____ (School or Program Name)

Name and address of health care provider authorized to:

- ❑ Send/disclose protected health information
- ❑ Receive/use educational information

_____

_____

Name and address of school/EI/ECSE program authorized to:

- ❑ Send/disclose educational information
- ❑ Receive/use protected health information

_____

_____

2. I understand that this information will be used for the following purposes (check all that apply):

- ❑ Determining eligibility for Special Education, EI/ECSE, or other services
- ❑ Determining student/child's current levels of performance
- ❑ Developing an individualized health plan
- ❑ Developing an appropriate Individualized Education Program or Individualized Family Service Plan
- ❑ Other (specify): _____

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

- ❑ Physician's Eligibility Statement
- ❑ Health Assessment Statement
- ❑ History and physical exam
- ❑ Entire medical record
- ❑ Prenatal information
- ❑ Educational Information
- ❑ IFSP/IEP document
- ❑ Clinic records
- ❑ Communicable disease(s)
- ❑ Progress notes
- ❑ Psychological evaluations
- ❑ Social work reports
- ❑ Other: _____

_____

4. By *initialing* the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.

___ Drug/alcohol diagnosis, treatment or referral information requested: _____

___ HIV/AIDS related records requested: _____

___ Mental health related information requested: _____

___ Genetic testing information requested: _____

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

c. I may revoke this authorization at any time by notifying _____ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

_____ (Signature of Parent, Legal Guardian, Student/Child) (Date)

_____ (Relationship)

This authorization expires on _____ (Month/Day/Year) (not to exceed one year from date of signature above).

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Authorization to Use and/or Disclose Educational and Protected Health Information

Purpose of form:

- This form was created so that educational agencies could request information from health entities that require HIPAA-compliant release forms. (HIPAA: Health Insurance Portability and Accountability Act)

- This form is used when there is a need to obtain consent from a parent, legal guardian or student/child to authorize the named agency to:
  - Send/disclose protected health information and/or educational information; and/or
  - Receive/use protected health information and/or educational information

Directions for completing form:

Box 1. Required.

- Enter the student/child's full legal name including middle name;
- Enter other names used by the child including nicknames;
- Enter child's date of birth;
- Enter the name and address of the health care provider who will send or receive requested protected health and/or educational information;
- Enter the name and address of the school district or EI/ECSE program sending or receiving the requested protected health and/or educational information; and
- Check all appropriate boxes that apply indicating which provider is authorized to send and which provider is authorized to receive protected health and/or educational information.

Box 2. Required.

- Mark all the boxes that apply regarding how the requested protected health and/or educational information will be used. For a record that is not represented in the list, check the "other" box and specify a different type of purpose.

Box 3. Required.

- Mark all the boxes that apply regarding which specific medical and/or educational records are being requested. For a record that is not represented in the list, check the "other" box and specify a different type of record.

Box 4. Required only if any of the four types of records indicated are requested. This box should be left blank if none of these four types of records are requested.

- The four types of records indicated require an additional level of protection. To request any record in Box #4, the specific type of record must be listed in the spaces provided and the parent, legal guardian or student/child must initial the space before each type of record requested. For example, for mental health information, a program might indicate "psychologist's assessment" and then the parent, guardian or student/ child would initial the space at the beginning of the mental health information line.

Box 5. Required.

- This box contains information relating to the parent's, guardian's, or child's rights in giving authorization including the right to refuse to sign, the right to request a copy after signing, the right to inspect the information to be used and/or disclosed, and the right to revoke the authorization. Information is given that clarifies that when requested information is sent, the laws that protect that information may no longer apply since the receiving agency may not be bound by the same laws as the sending agency.
- In item c., identify who will receive the potential revocation. The statement clarifies that if an action has already been taken, for example, protected health information has already been sent, then the revocation for that specific information is not valid. However, the agency may voluntarily return the information received after the revocation has been signed and submitted.

Box 6. Required.

- Parent, legal guardian, or student/child must sign for the authorization to be valid. If parent or guardian, the relationship to the child must be indicated. The date of the signature must be entered.
- The authorization is only valid for the purposes checked or stated in the form.

Box 7. Required.

- The month, day, and year that this authorization will expire must be included in the space provided. The date must not go beyond one year past the date of the signature.

Additional directions

- Place a copy of this form into the student/child's file.
- HIPAA requires that the school district/EI/ECSE program give a copy of the authorization form to individuals who sign it and request a copy. However, it is recommended practice that the school district/program automatically give the parent, guardian, or student/child a copy of the form after they have signed it, whether or not they request it, so they will have a record of the authorization.