RURAL CHAMPAIGN COUNTY SPECIAL EDUCATION COOPERATIVE
807 N. Mattis Ave, Champaign, IL 61821
217-892-8877 FAX: 217-893-8627

REQUEST FOR SCREENING AND CONSULTATION
Child Review Team Procedures Packet

Student:_____ Grade: _____ Age _____ Yrs _____ Mos. Birthdate: _____

School _____Teacher _____Current or Previous Services_____

Referred by _____ Date of Request _____ Date Parent Notified/Invited to CRT_____

Parents _____ Address _____

Phone (H) _____ (W) _____

Estimated Reading Level _____ **Estimated Math Level** _____

Other _____

Describe what you would like the student to be able to do that he/she does not currently do.

_____
_____
_____

Describe the student's strengths.

_____
_____
_____

Document at least three strategies/modifications implemented in the classroom to address the area of concern prior to CRT referral.

Description of Strategy _____

Date Implemented _____ Length of Implementation _____ (Person Responsible for Implementation) _____

Effect_____

Description of Strategy _____

Date Implemented _____ Length of Implementation _____ (Person Responsible for Implementation) _____

Effect_____

Description of Strategy _____

Date Implemented_____ Length of Implementation _____ (Person Responsible for Implementation) _____

Effect_____

Description of Strategy _____

Date Implemented_____ Length of Implementation _____ (Person Responsible for Implementation) _____

Effect_____

Attach or bring to the CRT meeting relevant work samples, standardized test results, classroom tests, and anecdotal records, etc.