



**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.**