



Request for Services

Please complete this form and return it to:
Debra Quain
Kankakee Area Special Education Cooperative
P.O. Box 71 St. Anne, IL 60964
Phone: 815-422-4151 FAX: 815-427-8409

Complete if requesting services for a student:

Student name:	Birthdate:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
District of residence:	Serving district:	School:
Teacher:	Grade/Program:	Currently receiving Spec. Ed. <input type="checkbox"/> Yes <input type="checkbox"/> No
Referral person:	Position:	Phone:
Contact person:	Position:	Phone:
Parent/Legal Guardian:		
Address:	City:	State: Zip code:
Home phone:	Work phone:	Cell phone:

TYPE OF SERVICE REQUESTED

<input type="checkbox"/> Occupational Therapy evaluation	<input type="checkbox"/> Audiological evaluation
<input type="checkbox"/> Vision assessment (must have ocular report prior to assessment)	<input type="checkbox"/> Behavior consultation
<input type="checkbox"/> Other	<input type="checkbox"/> Other

Reason for request:

Additional comments:

Referring person's signature Date

District Superintendent/Designee's signature Date