

PR-04 REFERRAL FOR EVALUATION

CHILD'S INFORMATION

NAME: _____ ID NUMBER: _____
STREET: _____ GENDER: _____ GRADE: _____
CITY: _____ STATE: OH ZIP: _____
DATE OF BIRTH: _____

BUILDING OF CURRENT ATTENDANCE: _____

TEACHER(S): _____

STUDENT'S NATIVE LANGUAGE (if not English): _____

PARENTS' / GUARDIAN INFORMATION

NAME: _____
STREET: _____
CITY: _____ STATE: OH ZIP: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____

PARENT'S NATIVE LANGUAGE (if not English): _____

Reason for Referral:

EDUCATIONAL HISTORY

Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development:

Provide data from previous interventions, including Interventions required by rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

Number of school districts attended: _____

Years at present school building: _____

List schools/early childhood programs and dates:

ATTENDANCE:

Regular Irregular

Is this student age-appropriate for grade level? Yes No

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with Vision Hearing
Does the student Wear Glasses Use hearing aid(s)

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Does the student take medication Yes No

Does the student have any health/developmental/physical problems of which you are aware? Yes No

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school

For Preschool Children Only *(please check the area(s) of concern):*

- | | | | |
|--|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Dressing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Receptive Communication | <input type="checkbox"/> Expressive Communication | <input type="checkbox"/> Hearing | <input type="checkbox"/> Gross Motor |
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> Fine Motor | <input type="checkbox"/> Play | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Social/Emotional Behavior | | |
| <input type="checkbox"/> Other | | | |

Describe any other pertinent information not previously described:

SIGNATURES

Signature of Person Initiating the Referral

Signature of Person Receiving the Referral

Position or Relationship to Student

Title

Date

Date Received

Date District Suspects a Disability

Permission to Consult

I, _____, hereby give my permission for the
Parent/Legal Guardian/Surrogate
_____ to respond to a request for assistance
School District
for _____.
Name of Child

I am giving my permission for the following assessments (***please check all that apply***):

- Review of relevant records (releases of information will be included)
- Interviews with caregiver, myself, teacher
- Observation(s) of my child
- Assessment (e.g., curriculum-based, screening, and other appropriate measures to determine interventions)
- Augmentative/Communication Evaluation (team decision making process for communication technology which includes meetings every 4 – 6 weeks and may include trials of assistive technology and/or picture communication systems.)
- Other (please specify): _____

I further understand and agree that the information collected by the school district will then be reviewed and the team will develop an intervention plan and designate the resources needed to implement these interventions.

Name of Parent/Legal Guardian/Surrogate

Signature

Date

HEARING SCREENING AND AUDIOLOGY CASE HISTORY FORM

HEARING SCREENING AND PHYSICIAN INFORMATION:

Student's Name: _____
Date of Screening: _____
Tester: _____

Student's Physician: _____
Physician's Address: _____
Physician's Phone: _____

SCREENING RESULTS

(Circle one response for each ear)

RIGHT EAR

LEFT EAR

Pass
Fail
Could Not Test

Pass
Fail
Could Not Test

IF "could not test" WAS CIRCLED, PLEASE EXPLAIN WHY THE CHILD COULD NOT BE TESTED:

AUDIOLOGY CASE HISTORY FORM

1. What kind of hearing problem do you feel your child has? _____

2. Has your child had his or her hearing tested before or seen a doctor about his or her ears? _____ If so, what did you find out? _____

3. Has your child ever had any serious illness, high fevers, blows to the head or significant noise exposure? _____ If so, explain. _____

4. Were there any problems during the pregnancy and birth of your child? _____

5. Is there anyone else in the family with a hearing problem? _____

6. Are your child's speech and language skills, social skills, academic skills, and general development similar to other children his or her age? _____ If not, explain. _____

Report any additional information which you feel would be helpful here. _____

Dear Parents/Guardians:

We would like to notify you that Region 14 – Hopewell Center has become eligible to receive Medicaid reimbursement for Augmentative Communication, Audiological, Speech Therapy Service, Occupational Therapy Services, Physical Therapy Services and Psychological Assessments. Unless we receive a note of denial or a phone call from you, we will be billing Medicaid for your child.

If you have any questions, please call Diane Mason at Region 14 – Hopewell Center, 937-393-1904 ext. 115.

Thank you.