

**Region 14 - Hopewell Center
 Consultation/Evaluation Referral Packet
 For Children 3 to 22 Years Old
 (Revised for 2011-2012 school year)**

Please use this packet to request the following Hopewell services:

- Consultation with Autism Resource Specialist

Please:

- 1. Provide the child's name and social security number below,**
- 2. Sign below, and**
- 3. Send this page along with all information listed for the Consultation with Autism Resource Specialist you are requesting.**
- 4. Send to Region 14 - Hopewell Center attention Diane Mason.**

Thank You!

I am requesting Region 14 - Hopewell Center provide the service(s) indicated below for;

 Child's Name

 Child's Social Security Number

Consultation with Autism Resource Specialist

- Copy** of Referral for Evaluation (Form PR-04) if this is an initial consultation **or** a re-evaluation
- Permission to Consult – **Enclosed**
- Autism Referral Information

Please indicate if student is P/S or School Age, type of referral & due date:

_____ *Preschool*

_____ *School Age*

- | | | |
|--------------------------|---------------------------|-----------------------|
| <input type="checkbox"/> | Transition Meeting | due date _____ |
| <input type="checkbox"/> | Initial Evaluation | due date _____ |
| <input type="checkbox"/> | Re-evaluation | due date _____ |

Has student been identified with a disability?	_____ Yes	_____ No
Is student on an IEP?	_____ Yes	_____ No
Is student on a 504 ?	_____ Yes	_____ No

 District Contact Person Signature

 District

 Date

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)

PR-04 REFERRAL FOR EVALUATION

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

Autism Referral Information

District _____

Date _____

Classroom _____

Student _____

_____ Consultation (Circle One)

1x Specific Need _____

On going Specific Need _____

_____ Follow up on consultation (quarterly problem solving meetings)

_____ Parent Support

Be Specific _____

_____ Community of practice/Staff development

Topic: _____

_____ Student's team members need support/training/more information on or related to:

_____ Help my district assess services for autism/low incidence students

Comments:

Permission to Consult

_____, 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