

**Region 14 – Hopewell Center
 Consultation/Evaluation Referral Packet
 For Children 3 to 22 Years Old
 (Revised for 09-10 school year)**

Please use this packet to request the following Hopewell services:

- MFE (initial)

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 MFE Initial evaluation 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

Initial (or second opinion initial) evaluation

- Copy of Referral for Evaluation (Form PR-04)
- Copy of IAT summary – use your district form
- Copy of Parent Consent for Evaluation (Form PR-05)
- Hopewell Planning Form (for Preschool or School-Age)
- Hearing Screening and Audiology Case History form
- Vision Screen and Case History form
- Motor Evaluation Information Sheet (for Preschool or School-Aged)
- Authorization for Release of Information
- NOTE: Please provide parents with Medicaid information sheet

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

PR-05 PARENT CONSENT FOR EVALUATION

TYPE OF EVALUATION

Initial Evaluation

Reevaluation (if additional assessment is to be conducted)

PART 1: TO GRANT CONSENT

I HEREBY GIVE MY PERMISSION FOR _____ to receive an evaluation(s) by designated personnel. I understand the evaluation information will be shared by teachers, principals, and other appropriate school personnel, and that the school district will forward educational records upon request to another school district or educational agency in which my child seeks or intends to enroll. I further understand that my granting of consent is voluntary on my part and I may revoke my consent at any time.

I have received a copy of my procedural safeguards and I understand the information provided.

Signature of parent/legal guardian/custodian, or student (if age 18 or older) _____ Relationship to Child _____ Date _____

PART 2: TO REFUSE CONSENT

(Do Not complete Part II if you completed Part I)

I have received a copy of my procedural safeguards and I understand the information provided.

I DO NOT GIVE MY PERMISSION for an evaluation for: _____

Reasons: (It would be helpful to school personnel who are designing an educational program to meet your child's unique needs if you would share with us your reasons for not giving your permission for an evaluation.)

Signature of parent, legal guardian, custodian, or student (if 18 or older) _____ Relationship to Child _____ Date _____

PART 3 (To be completed by the school)

Information about the evaluation and a copy of the procedural safeguards notice were presented/sent by:

Signature of school district representative _____ Date(s) _____

The parents' native language is _____

If not English, was the information provided in the native language or other mode of communication of the parents? YES NO

If no, explain:

If the native language or other mode of communication is not a written language, attach documentation of the steps taken to ensure that the notice was explained and that the parent understands the content of the notice.

Hopewell Evaluation Planning Form
Preschool

Child's Name: _____ Date of Birth: _____
Area(s) of Suspected disability: _____

Please check the assessment information you are requesting Hopewell Staff to provide:

- Pre-Academic/academic skills
- Adaptive Behavior
- Assistive Technology Needs
- Behavior Measure
- Cognitive Ability
- Hearing Abilities
- Motor Abilities
- Observation
- Social/Emotional Status

Hopewell Evaluation Planning Form
School-Age

Child's Name: _____ Date of Birth: _____
Area(s) of Suspected Disability: _____

Please check the assessment information you are requesting Hopewell Staff to provide:

- Achievement
- Adaptive Behavior
- Assistive Technology Needs
- Behavior Measure
- Classroom Observation
- Hearing Abilities
- Cognitive Ability
- Motor Abilities
- Social/Emotional Status
- Vision Abilities

HEARING SCREENING AND AUDIOLOGY CASE HISTORY FORM

HEARING SCREENING AND PHYSICIAN INFORMATION:

Student's Name: _____

Student's Physician: _____

Date of Screening: _____

Physician's Address: _____

Tester: _____

Physician's Phone: _____

SCREENING RESULTS

(Circle one response for each ear)

RIGHT EAR

LEFT EAR

Pass

Pass

Fail

Fail

Could Not Test

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. _____

VISION SCREENING AND CASE HISTORY FORM

Vision Screening Information:

Student's Name _____

DOB _____

Date of Screening _____

Tester _____

Screening Results:

Left Eye _____

Right Eye _____

Test Used _____

Vision Case History

1. Date of last vision examination: _____
2. Do you suspect that your child may have a vision problem? _____ Yes _____ No
3. If yes, please describe what you have noticed that makes you suspect a vision problem:

4. Does your child wear glasses? _____ Yes _____ No
5. Does your child hold books or other objects close to the face when reading or looking at them? _____ Yes _____ No
6. Does your child rub his/her eyes often? _____ Yes _____ No
7. Do your child's eyes water excessively? _____ Yes _____ No
8. Does your child squint when looking at things at a distance? _____ Yes _____ No
9. Does your child often walk or run into things? _____ Yes _____ No
10. Does your child ever confuse colors? _____ Yes _____ No
11. Does your child have problems copying written material? _____ Yes _____ No

Region 14 - Hopewell Motor Evaluation
Pre-school or School Age

Name: _____ Date of Birth: _____

District: _____ School: _____ Grade: _____

Please check service area(s) for which you are requesting an evaluation. Remember a doctor's prescription will be required for a Physical Therapy evaluation.

_____ Occupational Therapy

- ___ Fine Motor skills
- ___ Sensory/Attention Issues
- ___ Handwriting
- ___ Self Care in school setting
- ___ Feeding/Oral Motor
- ___ Adaptive Equipment

_____ Physical Therapy

(We will need a P.T. script to provide P.T. service)

- ___ Gross Motor Skills
- ___ Walking/Balance
- ___ Stair Climbing
- ___ Positioning in school
- ___ Wheelchair mobility
- ___ Wheelchair needs
- ___ Adaptive Equipment

_____ Adaptive Physical Education

- ___ Gross Motor Skills ofr P.E.
- ___ Modification/Adaptations for P.E.
- ___ Adaptive Equipment Recommendations

What is your main concern for this student:

Does the student have a current IEP? _____ Yes _____ No

Is there any other information you would like us to know about the student?

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.