

Community School Corporation of Eastern Hancock County

10370 E. 250 N.

Charlottesville, IN 46117

REQUEST FOR PSYCHOEDUCATIONAL EVALUATION

Revised December 2020

Please check the contents of this packet carefully to ensure that all sections are complete.

REFERRAL REQUIREMENTS:

- _____ CHECKLIST
- _____ PERTINENT INFORMATION
- _____ SOCIAL AND DEVELOPMENTAL HISTORY QUESTIONNAIRE
- _____ TEACHER/COUNSELOR REPORT
- _____ REFERRAL FOR EVALUATION
- _____ PARENT PERMISSION
- _____ WRITTEN NOTICE EVALUATION

DOCUMENTS TO ATTACH:

- _____ SUPPLEMENTAL TEACHER PAGES
- _____ RTI/PROGRESS MONITORING DATA
- _____ ILEARN/ISTEP, NWEA, IREAD3, DIBELS OR OTHER COMPETENCY TEST RESULTS
- _____ MOST RECENT REPORT CARD/TRANSCRIPT
- _____ ACHIEVEMENT TESTING DONE BY RESOURCE TEACHER (KTEA)
- _____ SYSTEMATIC OBSERVATION DONE BY RESOURCE TEACHER
- _____ SPEECH-LANGUAGE PATHOLOGIST REPORT
- _____ BEHAVIORAL SCREENING REFERRALS IF PREVIOUSLY COMPLETED
- _____ FUNCTIONAL BEHAVIORAL ASSESSMENT/BEHAVIOR INTERVENTION PLAN
- _____ DISCIPLINE LOG
- _____ MEDICAL REPORTS
- _____ OTHER _____

PERTINENT INFORMATION

STUDENT'S FULL LEGAL NAME: _____
STUDENT'S STATE ID NUMBER: _____ MEDICAL REPORTS: _____
CASE CONFERENCE COORDINATOR: _____
PRINCIPAL: _____
TEACHER: _____
SCHOOL CORPORATION OF RESIDENCE: _____

DOCUMENTS TO ATTACH:

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_____	OTHER _____

CONCERNS LEADING TO REFERRAL: (Check as applicable)

_____	READING DIFFICULTY
_____	MATH DIFFICULTY
_____	DIFFICULTY WITH WRITTEN EXPRESSION
_____	LEARNING ABILITY/APTITUDE
_____	VISION/HEARING LOSS
_____	BEHAVIOR/EMOTIONAL ADJUSTMENT
_____	MEDICAL/HEALTH/ORTHOPEDIC CONDITION
_____	OTHER (Please state) _____

Community School Corporation of Eastern Hancock County

SOCIAL AND DEVELOPMENTAL HISTORY QUESTIONNAIRE

(to be completed by parent/guardian)

Completion of this form is a required component of educational evaluations including speech-language evaluations.

A summary of this form will be included as part of the evaluation.

Person Completing Form: _____ Relationship to Student: _____

FAMILY INFORMATION:

Child: _____ Date of Birth: _____ Has the child been retained? _____

Address: _____

Name of Parent/Guardian 1: _____ Age _____

Education: _____ Phone: _____

Email: _____

Name of Parent/Guardian 2: _____ Age _____

Education: _____ Phone: _____

Email: _____

Child lives with: Parent 1 Parent 2 Other: _____

Parents are: Married Divorced Separated Other: _____

Please list the names of all people currently living at your child's residence:

Name	Relationship to child	Age

REASON FOR REFERRAL: check all that apply

academic social/emotional behavioral communication (speech/language)

1. What are the primary concerns?

2. What efforts have been made at home to address these concerns?

DEVELOPMENTAL AND MEDICAL INFORMATION:

1. Did the mother receive prenatal care? yes no Was the child carried to full term? yes no

2. Was the pregnancy considered normal? yes no Was the delivery considered normal? yes no

3. Child's weight at birth: _____ Child's length at birth: _____
4. Describe any complications during pregnancy or birth:

5. Did the child reach motor milestones (sitting, crawling, standing, walking, etc.) within normal limits?

6. Describe any motor delays and explain any services/supports received:

7. Did the child reach language milestones (gestures, first words, sentences, etc.) within normal limits?

8. Describe any language delays and explain any services/supports received:

9. Did the child receive services through First Steps? yes no What service?

10. Has the child had any vision, hearing or speech problems? yes no If yes, please explain:

11. Does the child have a history of any of the following: ear infections allergies
 impacted wax tubes in ears (date of insertion: _____)
12. Please list any academic problems, physical conditions, or mental health concerns that are present in your family:

13. Please describe any significant sensory issues that your child has experienced (e.g. over/under sensitive to sound, touch, smell, taste, visual stimuli): _____

List any serious illness, injury, hospitalization, surgery, or traumatic event:

Age	Description

List all current medical diagnoses (e.g., ADHD, asthma, allergies, anxiety, autism, bipolar, diabetes, etc):

Diagnosis	Date of diagnosis	Physician's name

List all current prescribed medications:

Medication	Dosage	Prescribing physician

SCHOOL AND ACADEMIC INFORMATION:

List, in order of attendance, the schools your child has attended:

School/Preschool/Daycare	Dates of attendance

1. How would you describe the child's effort level in school? low average high
2. Describe the child's work completion (in class, homework)? _____
3. Does the child receive any school related services (speech, OT, tutoring)? _____
4. Does the child receive any outside services (counseling, etc.)? _____
5. Does the child participate in any clubs or groups? _____

BEHAVIORAL HISTORY:

1. Describe how the child gets along with siblings, parents, and other family members: _____
2. Describe how the child gets along with peers at school and at home: _____
3. How is discipline handled at home and are the methods effective? _____
4. Are there factors (divorce, death, adoption, living situations, lack of contact with family members, etc.) that may play a significant role in the child's current functioning? Please describe: _____

OTHER PERTINENT INFORMATION:

1. Primary language spoken at home: _____
2. Please check the positive characteristics that describe the child:

<input type="checkbox"/> Good sense of humor	<input type="checkbox"/> Chooses similar aged friends
<input type="checkbox"/> Appears happy	<input type="checkbox"/> Has many interests
<input type="checkbox"/> Friendly	<input type="checkbox"/> Tries hard
<input type="checkbox"/> Liked by other children	<input type="checkbox"/> Likes school
<input type="checkbox"/> Good sport	<input type="checkbox"/> Other _____
3. Please check any that apply to the child:

<input type="checkbox"/> Lacks motivation	<input type="checkbox"/> Low self-concept
<input type="checkbox"/> Easily frustrated	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Cannot sit still	<input type="checkbox"/> Nail biting
<input type="checkbox"/> Overly talkative	<input type="checkbox"/> Depressed
<input type="checkbox"/> Short attention span	<input type="checkbox"/> Anxious
<input type="checkbox"/> Daydreams frequently	<input type="checkbox"/> Unusual fears
<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Has few close friends
<input type="checkbox"/> Aggressiveness	<input type="checkbox"/> Does not sleep well
<input type="checkbox"/> Shyness	<input type="checkbox"/> Frequent physical complaints
<input type="checkbox"/> Cries easily	<input type="checkbox"/> Difficulty making decisions

- Blames others for mistakes
- Poor appetite
- Other: _____

- Very disorganized
- Lies
- Other: _____

4. Have other professionals or agencies worked with the child or family? (e.g. children's hospital, mental health facility, child/family services, behavior therapist, etc.) If so, please explain:

5. Has the child been evaluated by someone other than the public school? If so, please explain and attach the evaluation report _____
6. List the child's academic strengths _____
7. List the child's social/interpersonal strengths: _____
8. List the creative or athletic strengths the child possesses: _____

Please return this form, along with any other paperwork relevant to your child's evaluation, to the school counselor

COMMUNICATION HISTORY:

1. At what age did you notice communication concerns for the child (e.g. for articulation, voice, fluency, social skills, and/or language skills) _____
Please describe what you observed _____

2. For articulation, how much of your child's speech is intelligible (understood) to a familiar listener?

3. Does the child have difficulty with oral motor skills (e.g. sucking/chewing/eating/drooling/difficulty using tongue/lips, etc.)? If yes, please describe:

4. For fluency/stuttering, when do you notice the child's dysfluencies? _____
_____ How often do they occur? _____
5. For language, please check the following areas that may be of concern to you:
 - difficulty following directions
 - difficulty learning to read
 - difficulty interacting with peers
 - difficulty learning rhymes
 - difficulty learning new concepts
 - difficulty asking/answering questions
 - difficulty initiating/maintaining conversation
 - difficulty with grammar (speaking or writing)
 - other _____

Please return this form, along with any other paperwork relevant to your child's evaluation, to the school counselor

SUPPLEMENTAL TEACHER FORMS

(general education teacher: complete pages 6-8 and return to referral coordinator)

TEACHER REPORT OF GENERAL EDUCATION INTERVENTION

Accommodations provided: (check all that apply)

_____	Praise/Rewards	_____	Verbal prompts (teacher/peer buddy)
_____	Redirection	_____	Small group work/Partner
_____	Self-check/self-monitor	_____	Timer
_____	Shortened assignments	_____	Homework contract
_____	Tests read aloud	_____	Additional work time
_____	Assignment notebook	_____	Allow corrections of work
_____	Other: _____		

Research Based Interventions: e.g. Reading Mastery, Corrective Reading (attach assessment data)

	<u>Intervention</u>	<u>Started</u>	<u>Frequency</u>	<u>Effectiveness: 1 (not)- 5 (very)</u>
1.	_____			
2.	_____			
3.	_____			

Additional Interventions: e.g. Tutoring, Remediation Specialist, Title I, Individualized Instruction, School Counseling, Behavior Plan

	<u>Intervention</u>	<u>Started</u>	<u>Frequency</u>	<u>Effectiveness: 1 (not)- 5 (very)</u>
1.	_____			
2.	_____			
3.	_____			

TEACHER REPORT OF ACADEMIC DIFFICULTY

STUDENT'S NAME _____ GRADE _____

AUDITORY PERCEPTUAL SKILLS *(Check problems observed)*

- Difficulty discriminating between similar sounds, blends, letters, or words (please specify/circle)
- Difficulty following oral directions
- Difficulty with sound/symbol relationships

VISUAL PERCEPTUAL SKILLS *(Check problems observed)*

- Difficulty discriminating shapes, sizes, color words
- Confuses similar letters (b/d, n/u, p/q, etc.)
- Difficulty finding/keeping place on visual tasks
- Difficulty copying at desk (near distance tasks)
- Difficulty copying from the board (far distance task)

READINESS SKILL ASSESSMENT *(Check if applicable for grade and age)*

- Student has adequate pencil grasp.
- Student can write his/her first name.
- Student can count to ten.
- Student can say the alphabet.
 - Student identifies approximately _____ numbers.
 - Student writes approximately _____ numbers.
 - Student identifies approximately _____ letters.
 - Student writes approximately _____ letters.

READING ASSESSMENT *(To be completed by the student's reading teacher)*

- Degree of reading difficulty: Mild Moderate Severe None
- Problems observed/identified in the student's reading (Check as applicable):
- Difficulty with phonological awareness
 - Difficulty remembering words previously learned/seen frequently
 - Difficulty learning new vocabulary words
 - Difficulty with phonetic skills
 - Difficulty with structural skills (prefixes, suffixes, root words, etc.)
 - Makes reversals or substitutions in reading (was/saw, what/that)
 - Reads word-to-word or at a slow rate
 - Ignores grammatical markers
 - Difficulty comprehending what is read
 - Other: _____

READING CURRICULUM MODIFICATIONS: _____

MATHEMATICS ASSESSMENT (To be completed by the student's mathematics teacher)

Degree of mathematics difficulty: Mild Moderate Severe None

Problems observed/identified in the student's mathematics (Check as applicable):

- Difficulty with math computation Difficulty with abstract math
- Difficulty understanding basic math concepts Difficulty with story problems
- Difficulty memorizing math facts
- Other: _____

MATHEMATICS CURRICULUM MODIFICATIONS: _____

WRITTEN EXPRESSION ASSESSMENT (To be completed by the student's language arts teacher)

Degree of writing difficulty: Mild Moderate Severe None

Problems observed/identified in the student's written expression (Check as applicable):

- Difficulty with handwriting Difficulty with spelling
- Difficulty with mechanics Difficulty with syntax
- Difficulty with grammar
- Difficulty with thought expression
- Other: _____

WRITTEN EXPRESSION CURRICULUM MODIFICATIONS: _____

COMMENTS/CONCERNS: _____

Name of General Education Teacher Completing This Form