

NSSEO REFERRAL for NEEDED ASSESSMENT(S)

Student Name _____ Birthdate _____ M / F District _____
 Address _____ City _____ Zip code _____
 Parent/Guardian _____ Home Phone _____ Work Phone _____
 School _____ Grade _____ Teacher _____
 Contact Person/Title _____ Phone _____ Email _____
 Current Eligibility/Program (if any) _____ Current Medical Diagnosis (if any) _____
 Check One: English Bilingual (specify) _____ Does the parent need an interpreter? Yes No
 Vision: P / F _____ (Date) Hearing: P / F _____ (Date) Referred to D/HH _____ (Date)

Please Note: Referrals for evaluations cannot be processed until vision and hearing screening (and follow-up if necessary) are completed.

TYPE OF ASSESSMENT(S) REQUESTED

- HEALTH HISTORY** Consult/Review of Records Evaluation Re-evaluation
- VISION** Consult Evaluation Re-evaluation Review of Records
 Screening Orientation and Mobility Medical Clinic Functional Assessment
 Rehabilitation Other (specify) _____
- SOCIAL/EMOTIONAL STATUS** Consult Evaluation Re-evaluation Review of Records
 Developmental History Emotional/Behavior Attention Complex FBA
- GENERAL INTELLIGENCE** Consult Evaluation Re-evaluation Review of Records
 Intellectual Functioning/Processing Specialized (specify) _____
- ACADEMIC PERFORMANCE** Consult Evaluation Re-evaluation Review of Records
 Current Levels Processing/Learning Style
- COMMUNICATION STATUS** Consult Evaluation Re-evaluation Review of Records
 Language Articulation Fluency/Voice Assistive Tech Other
- MOTOR ABILITIES** Consult Evaluation Re-evaluation Review of Records
 Fine Gross Sensory Adapted Physical Education (APE)
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- SPECIALIZED MEDICAL EVALUATION**
 Neurological Psychiatric Other (specify) _____

ATTACH referral questions for assessment(s) requested. (See backside for additional info)

 Building Representative/Date

 Administrative Representative/Date

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH REFERRAL

FOR ALL EVALUATION REQUESTS:

- Current vision and hearing screening results within the last 12 months. If the student fails either screening, follow-up (medical, D/HH, etc.) must occur before the referral can be processed.
- Signed “*Parent/Guardian Consent for Evaluation*” and “*Identification of Needed Assessments*” forms. Items listed on this informed written consent should match the evaluations requested on the “*NSSEO Referral for Evaluation or Consultation*” form.
- “*Referral Questions To Be Addressed*” in the domain areas of concern.
- Pertinent educational reports (team notes, work samples, intervention, efforts/outcomes).
- Current IEP, if the student has one and most recent case study reports, if not completed by DESC staff.
- Pertinent medical and/or hospitalization reports.
- Pertinent independent evaluations.

ADDITIONAL INFORMATION IS REQUIRED FOR THE FOLLOWING:

For All Bilingual Evaluations:

- “*Background information for Bilingual Students*”, including results of ACCESS for ELLS/language proficiency testing

For Bilingual Communication Evaluations:

- S/L Team Input: Language-Bilingual Pragmatic Language (PreK - 12th Grade)*
One of the following forms, depending upon the student’s grade:
- S/L Team Input: Language-Bilingual Oral Language-Listening & Speaking (EC)*
- S/L Team Input: Language-Bilingual Oral Language-Listening & Speaking (K-2)*
- S/L Team Input: Language-Bilingual Oral Language-Listening & Speaking (3-5)*
- S/L Team Input: Language-Bilingual Oral Language-Listening & Speaking (MS - HS)*

For Fine Motor, Gross Motor and Sensory Evaluations for OT/PT:

- “Physician Referral” for Evaluation
- “*Teacher Checklist for OT and/or PT Referral*”

For Gross Motor Evaluations for Adapted Physical Education (APE):

- “*Teacher Checklist for Adapted Physical Education Referral*”

For Specialized Medical Evaluations:

- Relevant medical history
- Copy of past neurological and/or psychiatric evaluations
- A written summary of the presenting concerns

For Vision Evaluations:

- “*Teacher Checklist for Possible Vision Problems*”
- Copy of previous reports from Optometrist or Ophthalmologist