

CAVELAND EDUCATIONAL SUPPORT CENTER

Referral Information

Student _____ Birthdate _____
 Sex _____ SSN _____
 Disability _____ Grade _____

School _____ Phone _____
 School District _____ Teacher _____
 Name and title of person requesting evaluation _____
 Name and title of person completing this referral _____

Reason for Referral (Please describe significant problems and when first noticed)

- Initial Referral Reevaluation Date Due: _____
 Consultation Functional Vision and Learning Media Assessment/Braille Skills
 Assistive Technology Evaluation (please specify):
 Computer-assisted Instruction
 Augmentative Alternative Communication
 Other _____

Briefly explain primary concern(s): _____

Previous Individual Testing

List other educational, psychological, speech/language, etc., test results.

Date	Test/Agency/Examiner	Scores/Results

Present and Past Supports

ESS	Past	Current		Past	Current
Chapter 1	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>
Remediation	<input type="checkbox"/>	<input type="checkbox"/>	Adaptive Physical Education	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Special Education	<input type="checkbox"/>	<input type="checkbox"/>	Kentucky School for the Blind	<input type="checkbox"/>	<input type="checkbox"/>
ESY _____			Current Classroom Placement		
Other (please specify) _____					

Has this student been evaluated for special education previously? Yes No

List services provided by community agencies: _____

Attendance Records

Original date of enrollment in current school _____
 Number of absences this school year _____ Number of tardies this school year _____
 Estimated total number of schools attended to date _____

Physical Functioning	Yes	No	Cognitive Functioning	Yes	No
Is the student ambulatory?	<input type="checkbox"/>	<input type="checkbox"/>	Does the student understand basic number concepts?	<input type="checkbox"/>	<input type="checkbox"/>
If not, can the student propel his/her own wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	Does the student understand basic time concepts?	<input type="checkbox"/>	<input type="checkbox"/>
Is the student able to use hands or fingers for pointing or touching?	<input type="checkbox"/>	<input type="checkbox"/>	Does the student understand basic money concepts?	<input type="checkbox"/>	<input type="checkbox"/>
If not, does student have other voluntary motion? Please specify:	<input type="checkbox"/>	<input type="checkbox"/>	Does the student understand the concepts of same/different?	<input type="checkbox"/>	<input type="checkbox"/>
Communication Capabilities	Yes	No	Social Competence	Yes	No
Does the student have a yes/no response? Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	Does the student follow school/classroom rules?	<input type="checkbox"/>	<input type="checkbox"/>
Does the student use words/phrases?	<input type="checkbox"/>	<input type="checkbox"/>	Is the student able to demonstrate self-control?	<input type="checkbox"/>	<input type="checkbox"/>
Does the student use signs/gestures?	<input type="checkbox"/>	<input type="checkbox"/>	Is the student able to demonstrate self-help skills?	<input type="checkbox"/>	<input type="checkbox"/>
Does the student respond to questions appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	Does the student exhibit consistent moods?	<input type="checkbox"/>	<input type="checkbox"/>
Does the student understand causal relationships in his classroom environment (i.e. look toward the TV as it is being turned on)?	<input type="checkbox"/>	<input type="checkbox"/>	Is the student able to effectively transition between activities?	<input type="checkbox"/>	<input type="checkbox"/>
Does the student notice new people in the environment?	<input type="checkbox"/>	<input type="checkbox"/>			
Vocational Functioning	Yes	No	Academic Performance	Yes	No
Does the student demonstrate independent work habits?	<input type="checkbox"/>	<input type="checkbox"/>	Can the student comprehend material read at grade level?	<input type="checkbox"/>	<input type="checkbox"/>
Does the student organize materials/belongings?	<input type="checkbox"/>	<input type="checkbox"/>	Can the student use math skills at grade level?	<input type="checkbox"/>	<input type="checkbox"/>
Can the student seek assistance as needed?	<input type="checkbox"/>	<input type="checkbox"/>	Can the student use writing skills at grade level?	<input type="checkbox"/>	<input type="checkbox"/>
Does the student use school/work tools effectively?	<input type="checkbox"/>	<input type="checkbox"/>	Can the student relate personal information?	<input type="checkbox"/>	<input type="checkbox"/>
Available Resources				Yes	No
Are there switch activated toys/appliances available in the classroom?				<input type="checkbox"/>	<input type="checkbox"/>
Is there a computer in the classroom? If so, what type?				<input type="checkbox"/>	<input type="checkbox"/>
Is the student regularly using a computer? How? (computer lab, assignments, educational games, other?)				<input type="checkbox"/>	<input type="checkbox"/>

For consultations, functional behavior assessments, and assistive technology evaluations please report this information if it is available. Please note that this information is required for psychoeducational evaluations.

Vision Screening

Glasses: Yes No

Date	Results	Examiner

If student was unable to complete traditional vision screening due to inability to understand instructions or comply with directions, answer the following questions to determine a gross estimate of the student's vision based upon day-to-day functioning in the classroom.

	Yes	No
Can see one inch objects on the floor	<input type="checkbox"/>	<input type="checkbox"/>
Can identify one inch objects by color at about 2 feet.	<input type="checkbox"/>	<input type="checkbox"/>
Can name common one inch objects as displayed at 2 feet.	<input type="checkbox"/>	<input type="checkbox"/>
Can follow source of light with eyes.	<input type="checkbox"/>	<input type="checkbox"/>
Holds objects at appropriate distance from eyes.	<input type="checkbox"/>	<input type="checkbox"/>
Is free from frequent squinting.	<input type="checkbox"/>	<input type="checkbox"/>
Uses both eyes when looking at an object (i.e. does not close one eye).	<input type="checkbox"/>	<input type="checkbox"/>
Eyes are free of excessive watering or tearing.	<input type="checkbox"/>	<input type="checkbox"/>

Hearing Screening

Hearing Aides: Yes No

Date	Results	Examiner

If student was unable to complete traditional hearing screening due to inability to understand instructions or comply with directions, answer the following questions to determine a gross estimate of the student's hearing based upon day-to-day functioning in the classroom.

	Yes	No
Responds to own name spoken in conversational tone.	<input type="checkbox"/>	<input type="checkbox"/>
Turns toward sound of coin dropped behind him/her.	<input type="checkbox"/>	<input type="checkbox"/>
Responds to ringing of soft hand bell.	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits response (startle reflex) to sudden loud noises (i.e. clap of hands) behind him/her.	<input type="checkbox"/>	<input type="checkbox"/>
Both ears are free from drainage.	<input type="checkbox"/>	<input type="checkbox"/>
Student is free from observable indications of ear problems (i.e. does not pull on or put fingers in ears).	<input type="checkbox"/>	<input type="checkbox"/>
Student uses both ears (i.e. does not consistently turn one ear toward sounds).	<input type="checkbox"/>	<input type="checkbox"/>

Speech/Language

Date	Results	Examiner