

REQUEST FOR SERVICE
STUDENT EVALUATION/CONSULTATION
 TAZEWELL-MASON COUNTIES SPECIAL EDUCATION ASSOCIATION
 300 Cedar St., Pekin, IL 61554-2576
 Phone: 309/347-5164 Fax: 309/346-0440

<u>EVALUATIONS</u>	<u>CONSULTATIONS</u>
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> ADOS <input type="checkbox"/> AUDIOLOGY <input type="checkbox"/> EDUCATIONAL/BEHAVIORAL <input type="checkbox"/> FUNCTIONAL VISION ASSESSMENT <input type="checkbox"/> MEDICAL REVIEW <input type="checkbox"/> OCCUPATIONAL THERAPY <input type="checkbox"/> PHYSICAL THERAPY </div> <div style="width: 35%; text-align: center;"> <u>LOW INCIDENCE EVALUATION</u> <input type="checkbox"/> INITIAL <input type="checkbox"/> RE-EVALUATION <input type="checkbox"/> SCHRAMM </div> </div>	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> ADAPTIVE P.E. <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> AUTISM <input type="checkbox"/> EDUCATIONAL/BEHAVIORAL STRATEGIES <input type="checkbox"/> FUNCTIONAL CURRICULUM <input type="checkbox"/> HEARING </div> <div style="width: 35%;"> <input type="checkbox"/> IEP FACILITATION <input type="checkbox"/> OCCUPATIONAL THERAPY <input type="checkbox"/> PHYSICAL THERAPY <input type="checkbox"/> SCHRAMM <input type="checkbox"/> TRANSITION <input type="checkbox"/> VISION </div> </div>

Evaluations will be completed and sent to district within 60 school days from date of parent consent. Consultation includes up to three IDEA funded visits with one report.

***If evaluation reports are needed prior to 60 school day timeline indicate anticipated date of IEP meeting _____**

NAME: _____ DOB: _____ Gender M F

PARENT/GUARDIAN: _____ PHONE: _____

ADDRESS: _____ E-MAIL: _____

SCHOOL DISTRICT: _____ ATTENDING SCHOOL: _____

TEACHER: _____ GRADE: _____ BEST TIME TO VISIT _____ (IF ECE AM OR PM)

PRIMARY LANGUAGE: _____ MODE OF COMMUNICATION: _____

MEDICAID: YES NO HAVE PARENTS GIVEN CONSENT TO BILL MEDICAID & IS IT ON FILE: YES NO

SPECIAL EDUCATION SERVICES: YES NO 504 SERVICES: YES NO

IF YES, CURRENT PROGRAM: _____

PRIMARY DISABILITY OR MEDICAL DIAGNOSIS:

RELATED SERVICES:

DESCRIBE HOW THE CHILD'S PROBLEM(S) ADVERSELY IMPACTS HIS/HER EDUCATIONAL PROGRAM:

DESCRIBE WHAT INTERVENTION STRATEGIES HAVE BEEN ATTEMPTED AND WITH WHAT RESULTS:

PERSON REQUESTING SERVICES: _____ DATE: _____

DISTRICT SPECIAL EDUCATION ADMINISTRATOR: _____ DATE: _____

Signature Required

CONTACT PERSON FOR SCHEDULING: _____

CONTACT PERSON'S PHONE: _____ E-MAIL: _____

CHECK ONE:

PARENT NOTIFICATION OF CONSULTATION DATE PARENT/GUARDIAN NOTIFIED: _____

PARENT CONSENT FOR EVALUATION (**ATTACH**) DATE PARENT/GUARDIAN SIGNED: _____