

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>
<p>AUDIOLOGY</p> <p><input type="checkbox"/> AUDITORY PROCESSING</p> <p><input type="checkbox"/> AUTISM EVALUATION</p> <p><input type="checkbox"/> EDUCATIONAL/BEHAVIORAL</p> <p><input type="checkbox"/> FUNCTIONAL BEHAVIOR ASSESSMENT</p> <p><input type="checkbox"/> FUNCTIONAL VISION ASSESSMENT</p> <p><input type="checkbox"/> MEDICAL REVIEW</p> <p><input type="checkbox"/> OCCUPATIONAL THERAPY</p> <p><input type="checkbox"/> ORIENTATION & MOBILITY (O&M)</p> <p><input type="checkbox"/> PHYSICAL THERAPY</p>	<p style="text-align: center;"><u>LOW INCIDENCE EVALUATION</u></p> <p><input type="checkbox"/> INITIAL</p> <p><input type="checkbox"/> RE-EVALUATION</p>
	<p><input type="checkbox"/> ADAPTIVE P.E.</p> <p><input type="checkbox"/> ASSISTIVE LISTENING EQUIPMENT</p> <p><input type="checkbox"/> ASSISTIVE TECHNOLOGY</p> <p><input type="checkbox"/> AUTISM</p> <p><input type="checkbox"/> BEHAVIOR</p> <p><input type="checkbox"/> FUNCTIONAL CURRICULUM</p> <p><input type="checkbox"/> HEARING</p> <p>IEP FACILITATION</p> <p><input type="checkbox"/> OCCUPATIONAL THERAPY</p> <p><input type="checkbox"/> ORIENTATION & MOBILITY</p> <p><input type="checkbox"/> PHYSICAL THERAPY</p> <p><input type="checkbox"/> SCHRAMM</p> <p><input type="checkbox"/> ROGERS ACADEMY</p> <p><input type="checkbox"/> TRANSITION</p> <p><input type="checkbox"/> VISION</p>

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: _____