



DIAGNOSTIC REQUEST FORM

ATTN: PILAR ROCHA
PHONE: 845-291-0200 x 10280
RETURN TO: PILAR.ROCHA@OUBOCES.ORG

DISTRICT: _____

CSE CHAIRPERSON: _____ PHONE NO. _____

STUDENT NAME: _____

GRADE LEVEL: _____

OU BOCES PROGRAM: _____

ASSESSMENT REQUESTS – (please check)

_____ OT

_____ PT

_____ PSYCHO-EDUCATIONAL

_____ SPEECH

_____ VISION

_____ HEARING

Evaluation(s) need to be completed by (M/D/Y): _____

Superintendent's Signature

Date