GWINNETT COUNTY PUBLIC SCHOOLS
EARLY CHILDHOOD PROGRAM
SPECIAL EDUCATION EVALUATION REFERRAL QUESTIONNAIRE

GENERAL INFORMATION

DATE FORM COMPLETED: _____ PERSON FILLING OUT FORM: _____

Child's Name: _____ _____ Preferred Name to be Called: _____
(First) (Middle) (Last)

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Please answer **both parts** of this two-part question.

1. Is the child Hispanic or Latino? ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino

2. Please select child's race(s) from the list below:
   ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
   ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

REASON FOR REFERRAL

Referred by: _____ Relationship: _____

Reason for referral (describe what concerns you most about your child and your reason for referral):
_____
_____
_____
_____
_____

When was the problem first noticed? _____

Has your child ever received a Developmental or Psychological evaluation? ☐ Yes ☐ No

If yes, when? _____ where? _____

HOME AND FAMILY INFORMATION

Home Address: _____
(Street) (City) (Zip Code)

Parent/Guardian Name: _____ Age: _____ Occupation: _____
☐ Mother ☐ Father ☐ Foster ☐ Guardian ☐ Step Cell Phone #: _____
Other Phone #: _____ E-Mail Address: _____

Parent/Guardian Name: _____ Age: _____ Occupation: _____
☐ Mother ☐ Father ☐ Foster ☐ Guardian ☐ Step Cell Phone #: _____
Other Phone #: _____ E-Mail Address: _____

Marital Status of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

HOME AND FAMILY INFORMATION (CONT.)

Child lives with: ☐ Both parents ☐ Mother ☐ Father Other: _____

If parents are separated or divorced, how old was the child when this occurred? _____

Is there another language (other than English) spoken in the home? ☐ Yes ☐ No
If yes, what language(s): _____ Is this the primary language in the home? ☐ Yes ☐ No
Language most frequently spoken to the child: _____ Primary language the child uses:_____
Interpreter needed: ☐ for parent ☐ for child ☐ both What language? _____

List all people currently living in the household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, list their names and ages:

Name	Age

Please check any condition that any member of the immediate family currently has or has had in the past (including family members receiving special education services). Indicate the relationship to the child.

Condition:	**Relationship to the child:**
☐ Learning Problems	_____
☐ Speech/Language Disorder	_____
☐ Attention Deficit Disorder	_____
☐ Hearing or Vision Impairment	_____
☐ Autism Spectrum Disorder	_____
☐ Other (_____)	_____

EARLY INTERVENTION AND/OR PRIOR SERVICES

Has your child received Babies Can't Wait OR any other private therapy services? ☐ Yes ☐ No
(If yes, complete the following) Service Coordinator/Provider:_____

Please indicate all services/therapies received:
☐ Speech Therapy ☐ Occupational Therapy ☐ ABA ☐ Feeding Therapy
☐ Physical Therapy ☐ Special Instruction ☐ Other (_____)

Does your child attend: ☐ Daycare ☐ Preschool ☐ Georgia Pre-K ☐ Head Start
Name of Daycare/Pre-K:_____
Address: _____
(Street) (City) (Zip)
Phone:_____ Teacher Name: _____

BIRTH/DEVELOPMENTAL HISTORY

Were there any complications during pregnancy/birth? ☐ Yes ☐ No
If yes, please describe: _____
_____

Did mother experience any problems with? (check all that apply)

☐ chronic disease	☐ trauma	☐ premature labor
☐ vaginal bleeding	☐ toxemia	☐ hypertension
☐ poor nutrition	☐ viral/staff infection	☐ gestational diabetes
☐ high blood pressure	☐ preeclampsia	☐ other_____

Was mother on medication? ☐ Yes ☐ No If yes, describe: _____
Did mother smoke? ☐ Yes ☐ No
Did mother drink alcoholic beverages? ☐ Yes ☐ No
Did mother use drugs? ☐ Yes ☐ No If yes, please list: _____
Was the child premature? ☐ Yes ☐ No If yes, how many weeks? _____

Type of delivery:

☐ vaginal delivery	☐ Cesarean Section
☐ forceps	☐ breech delivery
☐ vacuum suction	

Birth Weight: _____

Did your child spend time in the NICU? ☐ Yes ☐ No If yes, how long? _____
Reason for NICU stay? _____
Was baby discharged with mother? ☐ Yes ☐ No If no, how long was the baby hospitalized? _____

Were there feeding/swallowing problems? ☐ Yes ☐ No If yes, please describe: _____
Were there sleeping or breathing problems? ☐ Yes ☐ No If yes, please describe: _____
Were there any special problems during the first few years of life? ☐ Yes ☐ No
If yes, please describe: _____

The following is a list of developmental milestones. Please indicate the age at which your child demonstrated each skill.

Milestone	Age in Months	Milestone	Age in Months
Rolled over		Put several words together into phrases	
Sat alone		Fed Self with hands/fingers	
Crawled		Fed Self with utensils	
Walked alone		Dressed Self	
Babbled		Became toilet trained	
Said first word		Stayed dry at night	

MEDICAL/HEALTH INFORMATION

Has your child been diagnosed with any syndromes or medical conditions: ☐ Yes ☐ No If yes, please specify:

Diagnosis	Date Diagnosed	By Whom

Please indicate any of the following that your child currently has or had in the past.

Name	Current	Past	Name	Current	Past	Name	Current	Past
Allergies (FOOD)	☐	☐	Croup	☐	☐	Hypotonia	☐	☐
Allergies (MEDICINE)	☐	☐	Cytomegalovirus (CMV)	☐	☐	Meningitis	☐	☐
Allergies (SEASONAL)	☐	☐	Diabetes	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Diphtheria	☐	☐	Reflux	☐	☐
Bleeding Disorder	☐	☐	Eczema	☐	☐	Seizures	☐	☐
Cerebral Hemorrhage	☐	☐	Encephalitis	☐	☐	Tongue Tied	☐	☐
Chronic Colds	☐	☐	Fevers Over 104 Degrees	☐	☐	Tonsillitis	☐	☐
Chronic Headaches	☐	☐	Head Injuries /Concussion	☐	☐	Vocal Nodules	☐	☐
Cleft Palate	☐	☐	Heart Problems	☐	☐	Anemia:	☐	☐
Craniofacial Deformities	☐	☐	Hypo/Hyperthyroid	☐	☐	Other:	☐	☐

List any additional operations, hospitalizations, or injuries your child has had and at what age:

_____

_____

_____

_____

Does your child have a history of ear infections? ☐ Yes ☐ No How often? _____

If yes, has you child had tubes placed in their ears? ☐ Yes ☐ No

If yes, when/what age? _____ and how many sets over time? _____

Does your child use any assistive/adaptive devices? (check all that apply)

☐ glasses ☐ AFO's (Ankle-Foot Orthotics) ☐ walker/crutches

☐ wheelchair ☐ SMO's (Supra Malleolar Orthotics) ☐ hearing aid

☐ other: _____

Please list any medication your child is presently taking:

Medication	Dosage	Reason for Taking

COMMUNICATION DEVELOPMENT

	Yes	No
Do you have concerns regarding your child's communication development?	☐	☐
Is your child using words to communicate?	☐	☐
Does your child point, sign, and/or use gestures to communicate?	☐	☐
Does your child take you by the hand and guide you to what they want?	☐	☐
Does your child babble and/or use jargon (words that no one understands)?	☐	☐
Is your child using simple sentences to communicate (i.e., "see doggie")?	☐	☐
Is your child using longer sentences to communicate (i.e., "Look, the doggie is eating.")?	☐	☐
Is your child's speech difficult to understand?	☐	☐
Does your child stutter?	☐	☐
Is your child's voice usually hoarse or raspy?	☐	☐
Did your child's speech appear to develop and then stop?	☐	☐

COGNITIVE DEVELOPMENT

	Yes	No
Do you have academic concerns regarding your child?	☐	☐
Does your child respond to their name when called?	☐	☐
Does your child point to body parts when requested?	☐	☐
Does your child appear to be learning preschool concepts (i.e., big/small, more/less, in/out, on/off?)	☐	☐
Does your child appear to be learning colors, numbers, shapes?	☐	☐
Does your child point to pictures in a book when requested?	☐	☐
Does your child follow simple one-step directions (i.e., "go get your shoes")?	☐	☐
Does your child follow two- to three-step directions (i.e., "go get your shoes and sit down")?	☐	☐

PERSONAL/SOCIAL DEVELOPMENT

	Yes	No
Do you have personal/social concerns regarding your child?	☐	☐
Does your child prefer to play alone?	☐	☐
Does your child play alongside peers the same age?	☐	☐
Does your child share preferred toys with peers?	☐	☐
Does your child take turns when playing with peers?	☐	☐
Does your child have difficulty with changes in his/her routine?	☐	☐
Does your child follow directions related to his/her daily routine at home or school?	☐	☐
Does your child get frustrated easily?	☐	☐
Does your child show aggression when frustrated towards other? If yes, please explain:_____	☐	☐

MOTOR DEVELOPMENT

	Yes	No
Do you have concerns regarding the physical development of your child?	☐	☐
Is your child able to walk independently?	☐	☐
Is your child able to run independently?	☐	☐
Is your child able to jump independently?	☐	☐
Does your child have difficulty with coordination?	☐	☐
Can your child walk up and down stairs?	☐	☐
Is your child able to manipulate small items/toys?	☐	☐
Is your child able to stack blocks?	☐	☐
Does your child scribble on paper?	☐	☐
Is your child able to imitate or copy simple lines and/or shapes?	☐	☐

ADDITIONAL INFORMATION

	Yes	No
Is your child a picky eater?	☐	☐
Is your child highly sensitive to sounds?	☐	☐
Is your child highly sensitive to textures?	☐	☐
Does your child mouth toys or other nonfood items?	☐	☐
Does your child bite self or others?	☐	☐
Does you child seek out rocking, spinning, or swinging activities?	☐	☐
Does your child engage in head banging behaviors?	☐	☐
Does your child appear clumsy, often bumping into things, tripping, and/or falling?	☐	☐
Does your child frequently make loud and/or strange noises?	☐	☐
Does your child stare at spinning objects (i.e., wheels, fans, toys)?	☐	☐
Does your child display repetitive behaviors (i.e., lines up toys, waves hands in front of face, etc.)?	☐	☐

What are your child's favorite activities to do at home and/or preschool? _____

_____

What do you love the most about your child? _____

_____

Please include copies of any therapy reports or evaluations which might be helpful in our evaluation of your child.

Once you are ready to submit all necessary documents, please do so by:

Mail:
Gwinnett County Public Schools
Department of Special Education/Early Intervention Program
Building 200
437 Old Peachtree Rd., N.W.
Suwanee, GA 30024

Fax: 678-301-6663

Email: ecp@gcpsk12.org

Revised: 04/2022