DATE COMPLETED_____

Gwinnett County Public Schools
Early Childhood Program
SPECIAL EDUCATION EVALUATION REFERRAL QUESTIONNAIRE

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____Age: _____
(First) (Middle) (Last)
Sex: (circle) Male Female

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

1. Is the child Hispanic or Latino? (Circle one) No, not Hispanic/Latino Yes, Hispanic/Latino
2. Please select child's race(s) from the list below (Circle one or more that apply)
   American Indian or Alaska Native
   Asian
   Black or African American
   Native Hawaiian or Other Pacific Islander
   White

Home Address: _____
(Street) (City) (Zip)
Home Phone Number: _____ Neighborhood Elementary School: _____
Referred by: _____Relationship: _____
Address: _____Phone Number: _____
Person filling out form: (circle) Mother Father Stepmother Stepfather Other: _____

Reason for referral (describe what concerns you most about your child and your reason for referral):
_____
Describe your child's current difficulties_____
How long has the problem(s) been of concern to you? _____
When was the problem first noticed? _____
Has your child been diagnosed with any syndromes or medical conditions: Yes No If yes, please list or describe:
_____
Does you child attend: _____Daycare _____Preschool _____Governor's Pre-K ____Head Start _____Early Intervention Program/BCW_____
Name/Address/Phone # of the above:

HOME AND FAMILY INFORMATION

Mother's Name: _____ Age: _____ Education: _____
Occupation: _____Home Phone #: _____Work Phone #: _____
Cell Phone #: _____
E-Mail Address: _____ PREFERRED MEANS OF COMMUNICATION_____
(____Biological _____Adoptive _____Step _____Foster _____ Guardian_____)
Father's Name: _____ Age: _____ Education: _____
Occupation: _____Home Phone #: _____Work Phone #: _____
Cell Phone #: _____
E-Mail Address: _____
(____Biological _____Adoptive _____Step _____Foster _____ Guardian_____)
Stepparent's Name: _____ Age: _____ Education: _____
Occupation: _____Home Phone #: _____Work Phone #: _____
Cell Phone #: _____
E-Mail Address: _____ PREFERRED MEANS OF COMMUNICATION_____
Child lives with: (circle) Both parents Mother Father Other _____
Marital Status of Parents: (circle) Married Separated Divorced Widowed Single
If parents are separated or divorced, how old was the child when this occurred? _____
Primary language spoken in the home: _____
Other languages spoken in the home: _____
Is email ok to communicate with you?_____
Primary language spoken by the child_____
Is an interpreter needed for parent_____; for child_____. What language_____

List all people currently living in the household:

Name *Relationship to the child* *Age*

_____

_____

_____

_____

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

_____

_____

Please check any condition that any member of the immediate family has had. Please note the member's relationship to the child.

Condition: *Relationship to the child:*

_____ Learning Problems _____
_____ Speech/Language Disorder _____
_____ Attention Deficit Disorder _____
_____ Hearing or Vision Impairment _____
_____ Other ( ) _____

EARLY INTERVENTION SERVICES

Did your child receive Babies' Can't Wait Services? (circle one) YES No (If yes, list services?)

BCW Service Coordinator _____ Phone: _____

Service	Therapist Name	Presently Involved	No Longer Involved	Hrs/ per wk
Speech	_____	_____	_____	_____
Occupational Therapy	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Special Instruction	_____	_____	_____	_____

PREGNANCY/BIRTH HISTORY:

During pregnancy:
Were there any complications during pregnancy/birth? If yes, please indicate._____
_____

YES NO

Yes No Did mother experience problems with: _____chronic disease _____poor nutrition _____vaginal bleeding _____toxemia _____viral infection _____trauma _____premature labor _____hypertension _____gestational diabetes _____other _____

Yes No Was mother on medication?
(If yes, describe: _____)

Yes No Did mother smoke?

Yes No Did mother drink alcoholic beverages?

Yes No Did mother use drugs?
(If yes, please list: _____)

Yes No Were forceps used during delivery?

Yes No Was a vacuum suction used during delivery?

Yes No Was a Cesarean Section performed?

Yes No Was the child breech (feet first)?

Yes No Was the child premature?

Yes No If so, how many weeks? _____

Yes No If yes, please describe: _____

Birth Weight: _____

Yes No Was baby discharged with mother?

If no, how long was the baby hospitalized? _____

Yes No Were there any feeding/swallowing problems?

If yes, please describe: _____

Yes No Were there any sleeping problems:

If yes, please describe: _____

Yes No Were there any special problems during the first few years of life?

If yes, please describe: _____

DEVELOPMENTAL HISTORY

The following is a list of infant and preschool behaviors. Please indicate the age at which your child demonstrated each of the following.

Behavior	*Age*	*Behavior*	*Age*
Rolled over	_____	Fed Self	_____
Sat alone	_____	Dressed Self	_____
Crawled	_____	Became toilet trained	_____
Walked alone	_____	Stayed dry at night	_____
Babbled	_____		
Put several words together	_____		

MEDICAL/ HEALTH INFORMATION

Please circle any of the following that child has or had in the past.

Allergies	Chronic Headaches	Anemia
Craniofacial Deformities	Pneumonia	Reflux
CMV	Cerebral Hemorrhage	Croup
Diabetes	Chronic Colds	Diphtheria
Chronic Ear Infections	Ear Tubes/ Surgery	Seizures
Encephalitis	Heart Problems	Fevers Over 104 Degrees
Head Injuries /concussion	Bleeding Disorder	Tonsillitis
Vocal Nodules		Meningitis

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

_____ _____

_____ _____

Does your child use any assistive/adaptive devices? _____glasses _____braces _____walker/crutches

_____wheelchair _____hearing aide _____other: (please specify: _____)

Please list any medication your child is presently taking:

Medication	*Dosage*	*Reason for Taking*
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL/OTHER SERVICE PROVIDERS

Pediatrician _____ Phone: _____

Cardiologist _____ Phone: _____

Neurologist _____ Phone: _____

Gastroenterologist _____ Phone: _____

ENT _____ Phone: _____

Orthopedist _____ Phone: _____

Psychologist/Psychiatrist _____ Phone: _____

Ophthalmologist _____ Phone: _____

MOTOR DEVELOPMENT

Yes No Does your child have difficulty with walking, balance, stairs, jumping. If yes, please explain._____

_____

Yes No Does your child have difficulty with coordination?

Yes No Does your child use a wheelchair/walker?

Yes No Is your child able to stack blocks, hold a crayon or marker; copy simple lines/shapes; able to manipulate puzzle pieces and small toys?

COMMUNICATION

Do you have concerns about your child's communication development?
Explain: _____
_____

My child:

Yes No Gestures/points instead of using words
Yes No Uses Babbling (ex. baba, dada) , jargon (sounds like real words but are not)
Yes No Is difficult to understand? for family , unfamiliar people
Parent understands child's speech : none some about half most all
Yes No Uses words to communicate?
How many (circle) 0, 1-10, 10-20, 20-50, 50-100, more than 100
Yes No Uses phrases or sentences to communicate.
Circle: 2 word phrases, 3 word phrases, 4 word phrases, 5+ word phrases
Yes No Answers questions with words circle: who?, what?, where?, yes/no ?
Yes No Tells about a recent activity/event (ie: "I fell down.", " I saw dog.")
Yes No Points to pictures in a book on request.
Yes No Answers questions about a story?
Yes No Follows simple directions
Yes No Tell what is happening in a picture.
Yes No Speech appeared to develop and then stopped.
Yes No Does your child stutter? Is there a family history of stuttering problems? Yes No
Yes No Is your child's voice usually hoarse/ raspy?

How does your child communicate his wants and needs most often? _____.
How do your child's communication difficulties affect their daily life/ or participation in daycare?
_____.
What strategies have you used to improve these skills? _____.

SOCIAL

Yes No Do you have concerns about your child's socialization?
Yes No Does your child enjoy being around other children?
Yes No Does your child tolerate others in his personal space?
Yes No Does your child take turns when playing with others?
Yes No Does your child follow directions related to his/her daily routine at home or school?
Yes No Does your child get frustrated easily?
Yes No If "yes", what behaviors occur? (ie. Tantrums, refusal to participate? _____
_____
How often?_____
When does your child usually get frustrated? _____
Yes No Does your child experience anxiety (ie. Worry, bites nails, thumb sucks)?
If "yes", please describe: _____
_____
Yes No Does your child have difficulty paying attention?
Yes No Is your child aggressive toward others (ie. physical and/ or verbal aggression)
If "yes", please describe_____
Yes No Is cruel to animals
Yes No Difficulty with changes in routines
Yes No Highly sensitive to sounds
Yes No Highly sensitive to textures
Yes No Mouths toys frequently
Yes No Biting
Yes No Seeks out rocking, spinning, swinging
Yes No Head banging

What things have you tried to help your child with these behaviors ?_____
_____
Please list your child's strengths or what you enjoy about your child or what pleases you. Favorite activities or things to do at home.
_____
_____

COGNITION

Yes No Do you have any academic concerns ?
explain_____
_____

Yes No Does your child appear to be learning preschool concepts (big/small) (more/less) ; prepositions?
Yes No Does your child appear to be learning rote preschool concepts (colors, numbers, shapes)?

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 the following:

Mail:

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

Email:
ecse@gwinnett.k12.ga.us