_____ _____ _____

STUDENT TO BE SCREENED SCHOOL DATE OF BIRTH

_____ _____

Additional Testing Request Received in Special Services Special Services request forwarded to:

SPECIAL SERVICES REQUEST FOR SCREENING/EVALUATION

PLEASE COMPLETE THE SCREEING OR EVALUATION PROCEDURES INDICATED BELOW. **INDICATE THE DATE SCREENING OR EVALUATION PROCEDURES ARE COMPLETED, SIGN YOUR NAME AND RETURN THIS FORM ALONG WITH COPIES OF THE TEST RESULTS TO SPECIAL SERVICES. PLEASE KEEP THE TEST PROTOCOLS IN THE STUDENT'S FOLDER. RETURN THIS FORM WITH YOUR SIGNATURE TO KELLY D'ANGELO. DO NOT SEND ORIGINAL DOCUMENTS.**

PERSON COMPLETING THE REQUEST:

- ☐ Nurses, OT, PT
- ☐ Speech/Language Pathologist
- ☐ Audiologist
- ☐ AT Team Member
- ☐ Resource Consultant
- ☐ Special Services Teacher
- ☐ Behavior Consultant
- ☐ 504 Counselor

TYPE OF SCREENING OR EVALUATION TO BE COMPLETED:

- ☐ Vision
- ☐ OT Evaluation (☐ Fine Motor/Handwriting ☐ Sensory)
- ☐ Speech/Language
- ☐ Academic Screener
- ☐ Teacher of Visual Impairment Consultation
- ☐ Orientation & Mobility Evaluation
- ☐ Other
- ☐ Hearing
- ☐ PT Evaluation
- ☐ CAP Evaluation
- ☐ Adapted Physical Education Evaluation
- ☐ Assistive Technology Evaluation
- ☐ Learning Media Assessment
- ☐ Functional Vision Assessment

DATES NOTICES SENT TO SCHOOLS	
FIRST NOTICE SENT TO SCHOOL	
SECOND NOTICE SENT TO SCHOOL	
THIRD NOTICE SENT TO SCHOOL AND TO SPECIAL EDUCATION COORDINATOR	

Signature: _____ Date: _____

REVISED 9/20/17