



Date received by EC: _____

Date received by School Psych: _____

GATES COUNTY SCHOOLS
Exceptional Children's Program
P.O. Box 125
Gatesville, NC 27938
252-357-1113

REFERRAL FOR PSYCHOEDUCATIONAL EVALUATION

Student: _____ **Date of Birth:** _____
School: _____ **Grade:** _____
Teacher/s: _____ **Email:** _____
Parents' Names: _____ **Email:** _____
Person/s Initiating Referral: _____
Reason for Referral: _____

Please complete the following PRIOR to completing the Initial Referral:

INITIAL EVALUATION

DATE COMPLETED

Observation across settings

Summary of conferences with parents

Social/developmental history

2 Interventions

Data on Interventions

Vision

Hearing

Speech/language screening

Medicaid Form (if they have Medicaid)

Initial Evaluation	Date Completed	Reevaluation	Date completed
Referral	_____	Reevaluation	_____
Permission to test	_____	Permission to test	_____
90 day timeline	_____	Triennial due date	_____

Please check evaluations requested and attach signed copy of DEC 2 to referral form:

☐ Vision Screening	☐ Intellectual	☐ Speech/Lang Eval
☐ Hearing Screening	☐ Educational	☐ Communication Eval
☐ Speech/Language Screening	☐ Adaptive Behavior	☐ Motor Eval
☐ Health Screening	☐ Behavioral/ Emotional	☐ Medical Eval
☐ Motor Screen (Psych or OT?)	☐ Autism Assessment	☐ Audiological Eval
☐ Social/Developmental Hx	☐ ADHD Screening	☐ Other: _____

