

PINELLAS COUNTY SCHOOLS
ESE REQUEST FOR DIAGNOSTIC ASSESSMENT SUPPORT

Submit with Staffing Folder

Name: _____ DOB: _____ Student Number: _____

Student's Home Telephone #: _____ Date Form Completed: _____

Grade: _____ School: _____ Teacher(s): _____

Referral Agent/Contact Person: _____ Phone: _____

Current Placement/Services: _____

What additional information appears to be needed to assist the IEP Team in recommending services for this student? _____

Screening Dates and Results:

Hearing _____ ☐ P / ☐ F

Vision _____ ☐ P / ☐ F ; Does student need glasses? ☐ Y ☐ N Does he/she wear them? ☐ Y ☐ N

Speech/Language _____ ☐ P / ☐ F

Referral Concerns: _____

Attempts to Address Concerns: _____

Specific Questions that the Potential Evaluation/Consultation needs to address: _____

Student's Primary Care Physician Name/Number: _____

Current Medications (names and dosages): _____

Review Recommendation

☐ Neuropsychological consultation

☐ Diagnostic Assessment Support

☐ Medical evaluation: _____

☐ Other: _____