RE-EVALUATION

Special Education Referral
Phone: (218)-741-9201 ext. 0
Address: 8580 Enterprise Drive S., Mt. Iron, MN 55786
https://www.northlandsped.org/

Directions: When a student needs a **RE-EVALUATION, complete sections A through C** of this form at least 90 days prior to their evaluation due date and attach to an email to the school psychologist for your school, along with the student's most recent **REPORT CARD**. This is a **FILLABLE** form (as a Word document). Boxes are clickable. Text cues or the arrow symbol **(→)** indicate a field where text can be entered.

Please complete the entire form; it is needed for evaluation planning and this information is required for the evaluation report as part of a comprehensive evaluation.

Please mark the following goal/expectation for this evaluation referral:
☐Continuing service under current category →Click or tap here to enter text as needed
☐Change categorical placement (what category and why?): →
☐Met IEP goals; looking to exit from services →

A. Cover Page

Date: choose date		**MARSS #:** → Click or tap here to enter text.
Student Name: →		**Date of Birth**: → **Age**: →
Grade: choose or type	**Gender**: →	**Race/Ethnicity**: Choose
Has student repeated a grade(s)? ☐ **Yes** ☐ **No** **If yes, which grade(s)**: →		
Student's Current SPED Category: →		
List Previous SPED Categories, if any (e.g. DD): →		
Parents or Primary Caregivers Information (at least one main contact; if two parents will need to be contacted add 2nd):		
Name: →		**Relationship to student**: →
Email: →		**Phone**: →
Name: →		**Relationship to student**: →
Email: →		**Phone**: →
Name of IEP/Case Manager: →		
Email: →		**Phone/Ext**: →
Name/email of two additional teachers/staff who know student well (may be needed for electronic rating forms)**:**		
Name: →	Email: →	Position: →
Name: →	Email: →	Position: →
Resident District:→	**Providing District/School:** →	
IEP Dates: Year 1: → (mo/day/yr)	Year 2: →	Year 3: →
Date of Active/Current Eval Report: → (mo/day/yr)		

Services Currently Receiving (check all that apply):

☐ADAPT/In-School Counseling ☐ Outside Counseling ☐ Occupational Therapy ☐Physical Therapy
☐Physical Impairment ☐Adaptive PhyEd (DAPE) ☐Vision Impairment ☐Speech/Language
☐Targeted Services/Tutoring (if yes, describe): →
☐County Case Management (e.g. Social Services) ☐Other:→

B. Student's Performance and Relevant History

☐MCA or ☐MTAS Test Scores

Please record scores and indicate does not meet (DNM), partially meets (PM), meets (M), or exceeds standards (E)

Grade: →	Reading: Score Choose	Math: Score Choose	Science: Score Choose
Grade: →	Reading: Score Choose	Math: Score Choose	Science: Score Choose
Grade: →	Reading: Score Choose	Math: Score Choose	Science: Score Choose

Local Benchmark Scores (such as STARS, FAST, AIMSweb, etc.)

Please name the assessment & describe scores (e.g. benchmark expectation or percentile)

Reading enter name of test		**School Year**: enter, e.g. 19-20
Fall: score/describe	Winter: score/describe	Spring: score/describe
Math enter name of test		**School Year:** enter, e.g. 19-20
Fall: score/describe	Winter: score/describe	Spring: score/describe

Add additional test information here as needed: →

Describe communication skills:

☐Nonverbal ☐A few words ☐Phrase speech ☐Halting speech
☐Articulation errors ☐Poor grammar ☐Difficulty conveying thoughts/ideas ☐Slow oral response
☐Difficulty repeating back information ☐Fluent speech (average/above average speech/language skills)
☐Other (describe): →

If student is nonverbal or physically impaired, how do they functionally communicate their responses?

☐Signing ☐Picture board ☐Technology (describe): →
☐Other (describe): →

Please share Parent/Caregiver Updates, Concerns, Family Changes, etc:

→

Current school year attendance: **#Absences**: enter number	**#Tardies:** enter number

Has this child been assessed in another district or state? **☐Yes** **☐No**

If yes, please include a brief description: →

B. cont. Student's Performance and Relevant History

Does this student have a medical or mental health diagnosis? ☐**Yes** ☐**No**

Please check with student's parent/caregiver regarding medical or psychological evaluations completed outside of school since the last evaluation.

☐No additional evaluation has been done
☐Additional evaluation has been done (if checked, psychologist *may* need a copy in order to review testing)
☐Medical or psychological evaluation attached, **or**
☐Will follow up with psychologist to determine whether a copy of the evaluation is needed

Please have the nurse complete vision/hearing screening prior to sending in referral.
Report results:
Vision: ☐ Passed ☐ Failed Corrective lenses? ☐Yes ☐No
Hearing: ☐ Passed ☐ Failed Hearing Device? ☐Yes ☐No

If student has a hearing device, does the student have an amplification system? ☐Yes ☐No

If failed vision or hearing screening, report actions/steps being taken by nurse (e.g., rescreening date, parent follow-up): →

Medical Concerns-Health History (List diagnoses, medications, side effects, specialized health care procedures required, etc.):
→

Please share student's progress since last evaluation and any important information not addressed elsewhere on the referral:
→

C. Additional Concerns and Information

Check boxes for all concerns

Academic Skills

☐Basic Reading Skills (i.e., phonics)
☐Reading Fluency/ Low Words Correct Per Minute
☐Reading Comprehension
☐Difficulty Recalling Vocabulary/Concepts
☐Basic Math Skill
☐Math Facts
☐Math Calculations
☐Math Concepts/ Problem Solving
☐Spelling
☐Written Expression (ideas; grammar; mechanics)
☐Handwriting skills (legibility; fine motor control)
☐Listening Skills (e.g. recall; multi-step directions; comprehension of verbal information)
☐Oral Language (if checked, please also check appropriate boxes in communication skills area – previous page)
☐Other →

Performance/Work Production

☐Attention
☐Organizational Skills
☐Study Skills
☐Limited Endurance
☐Task Initiation
☐Task Completion
☐Limited Physical Strength
☐Attendance
☐Fatigue
☐Difficulty Concentrating
☐Planning and/or Sequencing Information
☐Other: →

Behavior

☐Verbally Aggressive
☐Physically Aggressive
☐Disruptive
☐Non-Compliant
☐Frequent blurting out
☐Hyperactive/ Impulsive
☐Withdrawn
☐Anxious
☐Disordered Thoughts (e.g., irrational, incoherent)
☐Atypical Behavior (e.g., delusional, extremely odd actions, self-injury) Describe: enter brief description
☒Other: →

Other

☐Fine Motor Skills (e.g. buttons, tying, using scissors, handwriting, typing, etc.)
☐Gross Motor Skills
☐Low Cognitive Ability
☐Communication Skills
☐Daily & Independent Living Skills
☐Social & Interpersonal Skills
☐Difficulty with Changes in Routine
☐Difficulty with Transitions
☐Difficulty Making Friends
☐Social Naiveté or Vulnerability
☐Other: →

Has a Functional Behavior Assessment (FBA) been completed for this student? ☐**Yes** ☐**No**

Does this student have a Behavior Intervention Plan (BIP) or (PBSP)? ☐**Yes** ☐**No**

If no, does the student need one based on their present behavior? ☐**Yes** ☐**No**

Include information about office discipline referrals.

☐Not applicable ☐See attached documentation Or, add a brief summary: →

☐Please attach the student's most recent Report Card

(Additional blank page below; feel free to copy and paste grade report, enter other information, etc.)