LADSE
The LaGrange Area Department of Special Education

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REFERRAL FOR EARLY CHILDHOOD EDUCATION EVALUATION

Child's Legal Name____
(First) (Middle) (Last)

Birth Date__________________________ M____ F_____

Address______________________________________City____________________Zip Code___________

Home Telephone_______________Resident School District__________School_______________________

Name of Father or Guardian________________________Work Phone________Cell Phone_______________

Name of Mother or Guardian________________________Work Phone________Cell Phone_______________

Sibling(s): Names and Ages____

THIS REFERRAL IS:

___ Phonological (attach Hodson screen)

___ Early Intervention (attach EI paperwork)

___ Private evaluation (attach any information)

___ Preschool Screen (attach screen protocols)

___ Parent initiated (attach screen protocols)

PRESCHOOL SCREENING RESULTS: Please mark as **PASS**, **FAIL**, or **RE-SCREEN** in each area

(Screen results are not required for children transitioning from Early Intervention)

____ Cognitive-Verbal _____ Perceptual-Motor _____ Vision _____ Hearing

____ Communication _____ Gross Motor _____ Behavior

PARENT CONCERNS INCLUDE:

______play skills ______fine motor skills (color, cutting) ______sensory processing

______social skills ______gross motor skills (running, jumping) ______communication skills

______behaviors ______speech articulation

Please further explain your concerns in any areas checked above:

____

____

____

____

LANGUAGE:

Is English the main language spoken in your home? Yes ____ No_____. If not, what language is spoken? ______________. Which language is spoken most often by your child?_______________

Which language is heard most often by your child?________________

Can one parent communicate in English? __________

PREVIOUS EVALUATION EXPERIENCES:

Has your child been evaluated by anyone in the last year? Yes_________ No_________

______Occupational therapy. If yes, where____

______Physical therapy. If yes, where____

______Speech/language therapy. If yes, where____

______Hearing/Vision. If yes, indicate pass/fail results: ______ Hearing _____ Vision

______Other. (Specify). Where____

CURRENT SERVICES:

What services does your child currently receive?

___ Developmental Therapy ____Social Work ____Physical Therapy ____Speech/Language Therapy

___ Occupational Therapy ____Other:____

Does your child have an EI service coordinator? If yes, who is it?_____________________________

SCHOOL EXPERIENCE:

If your child has attended or is attending a preschool or day care program, please indicate:

Name of school___________________________________Teacher/Director Name______________________

Address____

Phone__________________Days of attendance____

Does your child have any diagnosis which might affect educational programming? Please specify.

____

Does your child have any other health needs?____

____

Do you have any other concerns about your child that are not listed here?______________________

____

What do you hope to accomplish through this evaluation?_____________________________________

____

_________________________	__________	_________________________	__________
Parent Signature	Date	District Administrator Signature	Date