REQUEST FOR EVALUATION
ITINERANT SERVICES

PURPOSE: The purpose of these services is to provide a comprehensive assessment of students suspected of having low incident impairments (vision, hearing, physical handicaps). This information may assist in the modification of instruction and/or service eligibility.

EVALUATIONS/
CONSULTATION
PROVIDED: Vision, Hearing, Orthopedically Impaired

REQUEST FOR EVALUATION
PROCESS:

1. When/If a disability is suspected, contact the appropriate itinerant teacher to discuss concerns and information needed.

2. Following discussion, the request for evaluation is completed using these steps:
   1. Complete all elements of descriptive information on page 1.
   2. Put an X next to the evaluation(s) requested. <u>Note:</u> A current psychological evaluation is not required for submission but attach if previously completed.
   3. Complete the Teacher Summary Report on page 2.
   4. Provide responses to items on page 3.
   5. The itinerant teacher will assist with the completion of the Release of Information (page 4).
   6. The Ocular Report or doctor narrative must be completed and attached for an itinerant vision evaluation. The school nurse and/or itinerant vision teacher can assist.
   7. Obtain signatures of the Building Principal and the Special Education Coordinator for your district. Please follow up in obtaining these signatures as quickly as possible.

3. Submit the request for evaluation to the appropriate itinerant personnel at BHASED.

4. Itinerant teacher will contact local building personnel notifying them of receipt of request and to discuss and determine if a case study is warranted.

   * If the team decides a case study is warranted, ISBE 34-57 B, page 1 & 2 (Parent Consent for Evaluation) must be completed.

5. If the case study is completed, an IEP will be convened to determine eligibility and service recommendations.

REQUEST FOR EVALUATION - BHASED ITINERANT SERVICES

Student's Full Name: _____ Birthdate:_____ Sex: ____

District: _____ Building: _____ Grade: _____

Teacher: _____ Disability/Program Type: _____

Parent/Guardian: _____ Phone: (home)_____(work)_____

Address:_____

Request Prepared By: _____ Date:_____

DIRECTIONS: Please indicate the type of evaluation(s) being requested or suspected as necessary. In order for the request to be processed, documents for each category of evaluation are listed under the appropriate heading. Please attach copies of the documentation to this form.

___   **ORTHOPEDICALLY IMPAIRED ITINERANT EVALUATION**
___   Current Psychological (if previously completed)
___   Current IEP (if previously completed)
___   Release of information (medical/educational records)
___   Teacher Summary

___   **ITINERANT HEARING EVALUATION/CONSULTATION**
___   Current Audiological Report/School Hearing Test Results (**must be submitted with request**)
___   Release of Information (audiological/medical/educational records)
___   Current Psychological (if previously completed)
___   Teacher Summary Report
___   Current IEP (if previously completed)

___   **ITINERANT VISION EVALUATION/CONSULTATION**
___   Release of Information (optical/medical/education records)
___   Ocular Form (**must be submitted with request**)
___   Current Psychological (if previously completed)
___   Current IEP (if previously completed)

___   Teacher Summary Report

ISBE 34-57 A is required to notify the parent if a case study is appropriate or not.
If one is warranted, ISBE 34-57 B, page 1 & 2 (Parent Consent for Evaluation) must be completed.

TEACHER SUMMARY REPORT

The categories below should be filled in as specifically as possible, wherever relevant to the child being referred. Mark NP if no problem at this time.

1.	Academic Functioning (Reading, Spelling, Mathematics):

2.	Relations with peers and authority figures (shy, aggressive--may include emotional adjustment):

3.	Behavior (acting out, distractibility, hyperactivity, hypoactivity, etc.):

4.	Memory--long and/or short term (Auditory and/or Visual):

5.	Muscle Coordination (small and large):

6.	Reversals and transpositions (Reading, Writing, Spelling, Math):

7.	Speech and Language Development (receptive and expressive):

8.	Ability to listen and follow directions:

9.	Ability to complete tasks:

10.	Ability to do written assignments (manuscript or cursive):

11.	Ability to work independently, organize self and possessions:

12.	Attendance:

13.	Medical problems of which you are aware or would like checked (medications, enuresis, etc.):

14.	Special instruction (remedial classes, Mental Health, tutoring, etc.):

15.	Child's language use pattern, mode of communication, and cultural background:

16.	Other:

1. Please list pertinent health history information.

   _____
   _____
   _____
   _____

2. What specific instructional arrangements, teaching techniques, behavior management plans, and classroom adaptations have been used with this child? What was the result of each?_____

   _____
   _____
   _____
   _____
   _____

3. What agencies have professional contact with/on behalf of this child (Mental Health, Department of Children & Family Services, Office of Rehabilitation Services, Children's Therapy Center, etc.)?

   _____
   _____
   _____
   _____

Approved By:_____   Date:_____

       Building Principal

Approved By: _____   Date: _____

       Special Education Coordinator

PARENT RELEASE OF INFORMATION

_____ has been referred for an evaluation/consultation through the
Black Hawk Area Special Education District Diagnostic Services to determine his/her educational strengths and
needs and possible need for special education or related services.

Please send us a copy of the information indicated below. Thank you very much for your cooperation.

Type of Information Requested   _____

                                            Itinerant Teacher/Title

___   Ocular   Submit to:
___   Medical   Black Hawk Area Special Education District
___   Psychological   4670 - 11 Street
___   Educational   East Moline, IL 61244
___   Social/Behavioral
___   Audiological
___   Other: _____

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As parent/legal guardian of the above named child, I hereby grant my permission to
_____
         (individual or agency name e.g. Easter Seals, Iowa City, Doctor Name, etc.)

to exchange confidential information concerning my child with the Black Hawk Area Special Education District
and/or its contractually designated evaluator(s).

I understand that my permission covers the release of <u>permanent and temporary records,</u> and that I have the right to
inspect, copy and challenge the contents of these records and/or limit this consent to specific records or portions of
records which I have designated below.

You can rescind this permission at any time or it will automatically terminate one year from the date of
permission.

Parent/Guardian Signature:_____Relationship to child: _____

Address: _____   Child's Birthdate:_____

      _____   Date:_____