

**Region 14 - Hopewell Center
 Consultation/Evaluation Referral Packet
 For Children 3 to 22 Years Old**

Please use this packet to request the following Hopewell services:

- Motor Evaluation (Adapted Physical Education, Occupational Therapy, Physical Therapy)

Please:

1. Provide the information listed,
2. Provide the child's name and social security number below,
3. Please indicate if student has been identified with a disability,
4. Please indicate if student is on an IEP or 504, if so please attach,
5. Sign below,
6. Send this page along with all information listed for the Motor Evaluation (Adapted Physical Education, Occupational Therapy, Physical Therapy) you are requesting.
7. Send to Region 14 - Hopewell Center attention Mary Hiler.

Thank You!

I am requesting Region 14 - Hopewell Center provides the service(s) indicated below for;

_____ Child's Name _____ Date of Birth _____

Motor Evaluation

- Copy of Referral for Evaluation (Form PR-04) if this is an initial evaluation.
- Permission to Consult – **Enclosed**, page 4
- Motor Evaluation Information (Preschool or School-Age)
- Copy of Physical Therapy Prescription from Physician if P. T. is requested or permission to send completed evaluation to child's physician.

Please indicate if student is P/S or School Age, type of referral & due date:

_____ <i>Preschool</i>	_____ <i>School Age</i>
<input type="checkbox"/> Transition Meeting	due date _____
<input type="checkbox"/> Initial Evaluation	due date _____
<input type="checkbox"/> Re-evaluation	due date _____

Has student been identified with a disability?	_____ Yes	_____ No
Is student on an IEP?	_____ Yes	_____ No
Is student on a 504 ?	_____ Yes	_____ No

_____ District Contact Person Signature _____ District _____ Date

PR-04 REFERRAL FOR EVALUATION

CHILD'S INFORMATION

NAME: _____ ID NUMBER: _____
STREET: _____ GENDER: _____ GRADE: _____
CITY: _____ STATE: OH ZIP: _____
DATE OF BIRTH: _____

BUILDING OF CURRENT ATTENDANCE:

TEACHER(S):

STUDENT'S NATIVE LANGUAGE (if not English):

PARENTS' / GUARDIAN INFORMATION

NAME: _____
STREET: _____
CITY: _____ STATE: OH ZIP: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____

PARENT'S NATIVE LANGUAGE (if not English):

Reason for Referral:

EDUCATIONAL HISTORY

Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development:

Provide data from previous interventions, including Interventions required by rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

Number of school districts attended: _____

Years at present school building: _____

List schools/early childhood programs and dates:

ATTENDANCE:

Regular Irregular

Is this student age-appropriate for grade level? Yes No

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with Vision Hearing
Does the student Wear Glasses Use hearing aid(s)

PR-04 REFERRAL FOR EVALUATION

Does the student take medication Yes No

Does the student have any health/developmental/physical problems of which you are aware? Yes No

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school

For Preschool Children Only (please check the area(s) of concern):

- | | | | |
|--|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Dressing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Receptive Communication | <input type="checkbox"/> Expressive Communication | <input type="checkbox"/> Hearing | <input type="checkbox"/> Gross Motor |
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> Fine Motor | <input type="checkbox"/> Play | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Social/Emotional Behavior | | |
| <input type="checkbox"/> Other | | | |

Describe any other pertinent information not previously described:

SIGNATURES

Signature of Person Initiating the Referral

Signature of Person Receiving the Referral

Position or Relationship to Student

Title

Date

Date Received

Date District Suspects a Disability

Permission to Consult

I, _____, hereby give my permission for the
Parent/Legal Guardian/Surrogate
_____ to respond to a request for assistance
School District
for _____
Name of Child

I am giving my permission for the following assessments (please check all that apply):

- Review of relevant records (releases of information will be included)
- Interviews with caregiver, myself, teacher
- Observation(s) of my child
- Assessment (e.g., curriculum-based, screening, and other appropriate measures to determine interventions)
- Permission to evaluate child for therapy services.
- Permission to release therapy evaluation to child's physician.
- Other (please specify): _____

I further understand and agree that the information collected by the school district will then be reviewed and the team will develop an intervention plan and designate the resources needed to implement these interventions.

Child's Physician

Name of Parent/Legal Guardian/Surrogate

Address, City, State, Zip code

Signature

Phone #

Date

Region 14 - Hopewell Motor Evaluation
Pre-school or School Age

Name: _____ Date of Birth: _____

District: _____ School: _____ Grade: _____

Please check service area(s) for which you are requesting an evaluation. A physical therapy evaluation will require a doctor's prescription or permission from parent to forward P.T. evaluation to Doctor (on permission to consult page).

____ Occupational Therapy

- ___ Fine Motor skills
- ___ Sensory/Attention Issues
- ___ Handwriting
- ___ Self Care in school setting
- ___ Feeding/Oral Motor
- ___ Adaptive Equipment

____ Physical Therapy

- ___ Gross Motor Skills
- ___ Walking/Balance
- ___ Stair Climbing
- ___ Positioning in school
- ___ Wheelchair mobility
- ___ Wheelchair needs
- ___ Adaptive Equipment

____ Adaptive Physical Education

- ___ Gross Motor Skills of P.E.
- ___ Modification/Adaptations for P.E.
- ___ Adaptive Equipment Recommendations

What is your main concern for this student:

Does the student have a current IEP? ____ Yes ____ No

Is there any other information you would like us to know about the student?