**FOUR RIVERS SPECIAL EDUCATION DISTRICT**

**SCHOOL REPORT/REFERRAL FOR FULL AND INDIVIDUAL EARLY CHILDHOOD EVALUATION**

**Please complete all 3 pages and send in a copy of the birth certificate.** Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_

First Middle Last

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Parent/Guardian

Residing School District\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has child been enrolled in this program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was the child enrolled last year?\_\_\_\_\_\_\_

What days & times does the child attend your class/program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What curriculum and/or assessments are used?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Please send current assessment report***

Has the child ever attended any other program? (if yes, what?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has attendance been regular?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If not, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What services does the child receive? (i.e., speech therapy, counseling, OT/PT)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Concerns/Diagnoses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary language used by parents, if other than English \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If child is currently being monitored, how many weeks have you been implementing interventions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you requested a rescreen by the 4 Rivers Screening Team? Yes No An observation by 4 Rivers? Yes No

Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the parent been contacted regarding your concerns? \_\_\_\_ Has the parent been contacted about this referral? \_\_\_\_

**Screening Information:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Pass | Fail | UNC |
| Hearing |  |  |  |
| Vision |  |  |  |
| Date: |  | | |
| Agency: |  | | |

|  |  |  |
| --- | --- | --- |
|  | **DIAL-4** | |
|  | Score | % |
| **Language** |  |  |
| **Concepts** |  |  |
| **Motor** |  |  |
| **Overall** |  |  |
| Date: |  | |
| Agency: |  | |

|  |  |  |
| --- | --- | --- |
|  | **Speed DIAL-4** | |
|  | Score | % |
| **Overall** |  |  |
| Date: |  | |
| Agency: |  | |

Developmental Screening Recommendations *(please circle)*:

OK Monitor Speech

Directions: Please indicate what skills the child *already* has by placing a check mark (√) on the line in front of the skill. If there are no concerns in an area, please circle “No Concerns”. If there are concerns in an area, please explain in detail.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Cognitive/**  **Pre-academic** | **\_\_**operates mech. toys  \_\_matches pictures  \_\_sorts by shape/color  \_\_3 piece puzzle  \_\_understands “two”  \_\_points to pictures in books | **\_\_**names 2 colors  \_\_counts to four  \_\_recalls parts of story  \_\_shows imaginary play  \_\_understands same/different | | | \_\_names 4 colors  \_\_counts 10 objects  \_\_ids letter in name  \_\_retells short story  \_\_ids basic shapes  \_\_recognizes name in print | |
| No Concerns | **Concerns:** |  | | |  | |
| **Social/Emotional** | \_\_imitates others  \_\_shows interest in others  \_\_parallel play  \_\_brief interactive play  \_\_attends for 3 minutes | \_\_cooperative play  \_\_role playing  \_\_attends for 4 minutes | | | \_\_elaborate fantasy play  \_\_turn taking  \_\_follows rules  \_\_shows caring for others  \_\_stays with group  \_\_attends for 5 minutes | |
| No Concerns | **Concerns:** |  | | |  | |
| **Self-Care** | \_\_undresses self  \_\_needs minimal assistance with toileting  \_\_starting to use utensils | \_\_dresses self w/help  \_\_independent with toileting  \_\_washes hands  \_\_brushes teeth | | | \_\_Buttons, snaps, zips  \_\_puts on coat  \_\_dresses independently  \_\_uses utensils well | |
| No Concerns | **Concerns:** |  | | |  | |
| **Communication** | \_\_uses 3 word sentences  \_\_speech is understandable to familiar people  \_\_understands differences  \_\_follows 2 step direction  \_\_uses a wide variety of words | \_\_uses 4 word sentences  \_\_answers some “wh” ?s  \_\_speech is understandable to unfamiliar people  \_\_does not stutter  \_\_talks about activities | | | \_\_answers ?s about stories  \_\_communicates easily  \_\_uses correct grammar  \_\_says most speech sounds  \_\_uses sentences with details | |
| No Concerns | **Concerns:** |  | | | |  |
| **Gross Motor** | \_\_climbs playground equip  \_\_alternates feet on steps  \_\_kicks ball  \_\_runs easily  \_\_pedals tricycle | \_\_stands on one foot  \_\_throws overhand  \_\_catches bounced ball  \_\_uses stairs w/o railing | | | | \_\_hops  \_\_kicks/throws with accuracy  \_\_stands on one foot |
| No Concerns | **Concerns:** |  | | | |  |
| **Fine Motor** | \_\_draws lines and circles  \_\_use emerging tripod grasp  \_\_builds 6 block tower  \_\_screws and unscrews  \_\_turns book pages 1 at a time | | \_\_copies simple shapes  \_\_draws a person with 2 body parts  \_\_uses scissors  \_\_copies some capital letters | | | \_\_copies triangles  \_\_draws person with body  \_\_prints letters |
| No Concerns | **Concerns:** |  | | | |  |
| **Sensory Issues** | **\_\_**flapping/spinning  \_\_overreaction to sound  \_\_unusual sounds/words/echoing | | \_\_difficulty with routine  \_\_ atypical play  \_\_uncommon behaviors | | | \_\_difficulty transitioning  \_\_ poor eye contact  \_\_ self-harm |
| No Concerns | **Concerns:** | | |  | |  |
| **Additional Notes:** |  | | |  | |  |

**Please list any additional assistance given to this child to address the areas of concern. Common interventions are listed, but please add any additional activities.**

**\_\_\_\_**Sits by teacher in group

\_\_\_\_Extra one-on-one instruction

\_\_\_\_Extra small group instruction

\_\_\_\_Repeated instructions

\_\_\_\_Picture schedule

\_\_\_\_Verbal reminders of the

routine

\_\_\_\_Hand over hand assistance

\_\_\_\_Holding hands in hallway/transitions

\_\_\_\_Sitting on lap in group

\_\_\_\_Sensory tools Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other assistance/interventions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Title Date**

*Checklist adapted from the Center for Disease Control and Mayo Clinic*