CHUH Department of Early Childhood

Referral for Evaluation Packet

Dear _____

Re: B/D:

In response to your request , please find enclosed a "Referral for Evaluation "packet.

Please complete **ALL SECTIONS** of the following forms:

1. Parent / Guardian & Student Information Sheet
2. PR-40 Referral for Evaluation form
3. Devereux Early Childhood Assessment for Preschoolers (DECA-P2)
4. Family Survey

After completing all sections of the forms ,please return them to me at Gearity Professional Development School, 2323 Wrenford Road,University Heights,OH-44118 or you can email me at v_krishnan@chuh.org.

When your completed forms are received, they will be given to Kathleen Kotnik,Preschool Psychologist, at Gearity Professional Development School.You will be contacted by the preschool team to schedule a meeting to discuss your concerns in detail. The continuation of the referral process will be outlined for you at the initial meeting. If you have any questions prior to the initial meeting, please do not hesitate to contact Kathleen Kotnik at 216-320-5031.

Attention: Residency must be proven immediately following the completion of IEP.Registration packet can be picked up from nour main office at 2323 Wrenford Road, University Heights, OH-44118.Please contact me at 216-371-7356 or email at v_krishnan@chuh.org if you have any questions.

Sincerely,
Vritika Krishnan
Staff Assistant

Enclosures: RFE

Pick up Date: _____ Recd.on _____

PARENT/GUARDIAN & STUDENT INFORMATION SHEET

Parent/Guardian Information:

Parent Name:_____ Parent Name: _____

Address: _____

City/State/Zip: _____

Contact Numbers/Email: (Home Ph #): _____

(Cell): _____ (Cell): _____

Email:

Student Information: Please write the name as listed on the Birth Certificate.

Name: _____
(First) (Middle) (Last)

Date of Birth (mm/dd/year): _____

Birth City: _____

Gender: Male _____ Female _____

Ethnicity: Choose one: Hispanic _____ Non Hispanic _____

Race: Choose one or more regardless of ethnicity:

1. Black or African American _____ 2. White _____
3. Asian _____ 4. American Indian or Alaskan Native _____
5. Native Hawaiian or Other Pacific Islander _____

Native Language: English _____ Other _____

OFFICE STAFF: CC Staff Asst.

Devereux Early Childhood Assessment for Preschoolers Second Edition (DECA-P2)

(for children ages 3 through 5 years)

Paul A. LeBuffe ■ Jack A. Naglieri

Child's Name: _____ Gender: _____ Date of Birth: _____

Program/Site: _____ Classroom/Group: _____ Age: _____

Person Completing this Form: _____ Relationship to Child: _____ Date of Rating: _____

This form describes a number of behaviors seen in some young children. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the child...*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Please answer each question carefully. There are no right or wrong answers. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right. Please do not skip any items.

Never	Rarely	Occasionally	Frequently	Very Frequently
☒	☑	☐	☐	☐

Item#	***During the past 4 weeks, how often did the child...***	Never	Rarely	Occasionally	Frequently	Very Frequently
		✓	✓	✓	✓	✓
1.	act in a way that made adults smile or show interest in him/her?	☐	☐	☐	☐	☐
2.	listen to or respect others?	☐	☐	☐	☐	☐
3.	control his/her anger?	☐	☐	☐	☐	☐
4.	seem sad or unemotional at a happy occasion?	☐	☐	☐	☐	☐
5.	show confidence in his/her abilities (for instance, say "I can do it!")?	☐	☐	☐	☐	☐
6.	have a temper tantrum?	☐	☐	☐	☐	☐
7.	keep trying when unsuccessful (show persistence)?	☐	☐	☐	☐	☐
8.	seem uninterested in other children or adults?	☐	☐	☐	☐	☐
9.	use obscene gestures or offensive language?	☐	☐	☐	☐	☐
10.	try different ways to solve a problem?	☐	☐	☐	☐	☐
11.	seem happy or excited to see his/her parent or guardian?	☐	☐	☐	☐	☐
12.	destroy or damage property?	☐	☐	☐	☐	☐
13.	try or ask to try new things or activities?	☐	☐	☐	☐	☐
14.	show affection for familiar adults?	☐	☐	☐	☐	☐
15.	start or organize play with other children?	☐	☐	☐	☐	☐
16.	show patience?	☐	☐	☐	☐	☐
17.	ask adults to play with or read to him/her?	☐	☐	☐	☐	☐
18.	have a short attention span (difficulty concentrating)?	☐	☐	☐	☐	☐
19.	share with other children?	☐	☐	☐	☐	☐
20.	handle frustration well?	☐	☐	☐	☐	☐
21.	fight with other children?	☐	☐	☐	☐	☐
22.	become upset or cry easily?	☐	☐	☐	☐	☐
23.	show an interest in learning new things?	☐	☐	☐	☐	☐
24.	trust familiar adults and believe what they say?	☐	☐	☐	☐	☐
25.	accept another choice when his/her first choice was not available?	☐	☐	☐	☐	☐
26.	seek help from children/adults when necessary?	☐	☐	☐	☐	☐
27.	hurt others with actions or words?	☐	☐	☐	☐	☐
28.	cooperate with others?	☐	☐	☐	☐	☐
29.	calm himself/herself down?	☐	☐	☐	☐	☐
30.	get easily distracted?	☐	☐	☐	☐	☐
31.	make decisions for himself/herself?	☐	☐	☐	☐	☐
32.	appear happy when playing with others?	☐	☐	☐	☐	☐
33.	choose to do a task that was hard for him/her?	☐	☐	☐	☐	☐
34.	look forward to activities at home or school (for instance, birthdays or trips)?	☐	☐	☐	☐	☐
35.	touch children or adults in a way that you thought was inappropriate?	☐	☐	☐	☐	☐
36.	show a preference for a certain adult, teacher, or parent?	☐	☐	☐	☐	☐
37.	play well with others?	☐	☐	☐	☐	☐
38.	remember important information?	☐	☐	☐	☐	☐

Kaplan #TK
1-800 mailing TE:

CHUH Preschool Family Survey

Child's Name:_____ Date of Birth:_____

Who does your child live with? Please list name and relationship. _____

_____

_____

_____

Religious Affiliation:_____

Is your child adopted? ☐ yes ☐ no At what age? _____

Is your child aware of their adoption? _____

Is your child a foster child? ☐ yes ☐ no

How long has s/he been with your family?_____

Languages spoken at home:_____

How do you discipline your child at home?_____

How does your child react to discipline? _____

_____

School History

Has your child attended preschool or daycare before? ☐ yes ☐ no

Where?_____

How Long? _____

Has your child had any group experiences (i.e. library story time, Little Gym, etc)? ☐ yes ☐ no

What kind?_____

OVER

What does your child like to do at home?_____

_____

_____

_____

What games or toys does your child prefer:_____

_____

Please circle the words below that describe your child:

Friendly	Moody	Quiet	Aggressive	Good-natured	Emotional
Impulsive	Attentive	Sleepy	Fearful	Even-tempered	Stubborn
Caring	Happy	Shy	Dependent	Sympathetic	Energetic

Does your child enjoy reading books with you? ☐ yes ☐ no

How often do you read at home?_____

Who reads with your child at home?_____

Does your child nap?_____ What time?_____ How long?_____

What time does your child go to sleep at night? _____

What time does your child wake up in the morning?_____

Does your child play well alone? ☐ yes ☐ no

Does your child play well in groups? ☐ yes ☐ no

Does your child have any fears (i.e. animas, thunder, dark, etc)? _____

What are they?_____

Has your child had to face any difficult situations (hospitalization, moving, divorce, etc)?_____

_____

_____

_____

OVER

Does your child have frequent temper tantrums? ☐ yes ☐ no

Describe what might occur that would result in a temper tantrum: _____

_____

_____

Does your child:

Seem to be highly active? ☐ yes ☐ no

Seem to be unusually quiet? ☐ yes ☐ no

Seem to be a happy child? ☐ yes ☐ no

How long can your child attend to something of interest? _____

Do you have any concerns about your child's development (speech, fine motor, behavior)? If so, please explain.

_____

_____

_____

_____

What goals do you have for your child this school year? _____

_____

_____

_____

Is there anything else you would like to tell us about your child? _____

_____

_____

_____

_____

_____

_____

Cleveland Hts.-University Hts. City Schools
Student Services Department

Referral For Evaluation: Preschool Addendum

Additional Educational History:

1. Has the child participated in Early Intervention through Bright Beginnings? _____ Yes _____ No

Service Coordinator:

_____ _____
Name Phone Number

Can you provide a copy of your most recent IFSP? _____ Yes _____ No

2. Has the child attended or does the child currently attend a daycare, preschool or Head Start Program? _____ Yes _____ No. If Yes, please provide dates of attendance, contact person, address and phone number

a) Name of the facility: _____ Phone _____

Contact Person: _____

b) Name of facility: _____ Phone _____

Contact Person: _____

c) Name of facility: _____ Phone _____

Contact Person: _____

3. Has the child participated in private therapies? If Yes, Please complete below. ____ Yes ____ No
(i.e.Speech/Language, Occupation or Physical Therapy)

a) Name of Provider: _____ Phone _____

Type of therapy: _____ Dates of Therapy: _____

b) Name of Provider: _____ Phone _____

Type of therapy: _____ Dates of Therapy: _____

c) Name of Provider: _____ Phone _____

Type of therapy: _____ Dates of Therapy: _____

Cleveland Hts.-University Hts. City Schools
Student Services Department

Referral for Evaluation: Preschool Addendum

Additional Medical History:

1. Name of child's regular physician: _____ Phone: _____

2. When was the child's last physical examination? _____
   Date

3. Did the child's birth follow a full-term pregnancy with no complication prior to or immediately following delivery?
   If No, please describe. _____ Yes _____ No

4. Medical records and parent/guardian indicate a history of significant health concerns, major childhood illness/disease, or diagnosed syndromes? If Yes, please describe. _____Yes _____No

5. Does the child have food or environmental allergies? If Yes, please describe. _____Yes _____No

6. Does the child have adaptive or medical needs? If Yes, please describe. _____ Yes _____No
   (i.e.: hearing aids, glasses, wheelchair, catheter, walkers)

7. Is the child's vision within normal limits? _____ Yes _____ No
   Do you have documentation? _____ Yes _____No If Yes, date of Exam: _____

8. Is the child's hearing within normal limits? _____ Yes _____No
   Do you have documentation? _____ Yes _____No If Yes, date of Exam: _____

9. Please provide any other information that you think will be helpful for us to know about your young child:

Parent/Guardian Signature: _____ Date: _____

PR-04 REFERRAL FOR EVALUATION

CHILD'S INFORMATION

NAME: _____ ID NUMBER: _____

STREET: _____ GENDER: _____ GRADE: _____

CITY: _____ STATE: OH ZIP: _____

DATEOFBIRTH: _____

BUILDINGOFCURRENT ATTENDANCE:

TEACHER(S):

STUDENT'S NATIVE LANGUAGE (if not English):

PARENTS' / GUARDIAN INFORMATION

PARENT'S NATIVE LANGUAGE (if not English):

NAME: _____

STREET: _____

CITY: _____ STATE: OH ZIP: _____

HOMEPHONE: _____ WORKPHONE: _____

CELLPHONE: _____ EMAIL: _____

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)

Does the student take medication ☐ Yes ☐ No

If yes, specify type and purpose:

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

If yes, please explain:

B. Environmental Factors

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

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

- ☐ Eating
- ☐ Receptive Communication
- ☐ Cognitive
- ☐ Vision
- ☐ Other
- ☐ Dressing
- ☐ Expressive Communication
- ☐ Fine Motor
- ☐ Social/Emotional Behavior
- ☐ Toileting
- ☐ Hearing
- ☐ Play
- ☐ Attention
- ☐ Gross Motor

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

ASRS™ Short Form (2–5 Years)

Sam Goldstein, Ph.D. & Jack A. Naglieri, Ph.D.

Child's Name/ID: _____ Age: ____ Years ____ Months Gender: M F (Circle One) Today's Date: ____/____/____ Year Month Day

Parent's/Teacher's Name/ID: _____ Rater Type: Parent Teacher/Childcare Provider (Circle One) Birth Date: ____/____/____ Year Month Day

Childcare Setting: _____ Time Known Child: (for Teachers only) ____ Years ____ Months Age: ____/____/____ Years Months Days

Instructions: Read each statement that follows the phrase, "***During the past four weeks, how often did the child…,***" then circle the number under the word that tells how often you saw the behavior. Read each question carefully, then mark how often you saw the behavior **in the past four weeks.** Answer every question without skipping any. If you want to change your answer, put an X through it and circle your new choice. Be sure to answer every question.

During the past four weeks, how often did the child…	Never	Rarely	Occasionally	Frequently	Very Frequently
1. play with others?	0	1	2	3	4
2. look at others when interacting with them?	0	1	2	3	4
3. have trouble talking with other children?	0	1	2	3	4
4. choose to play alone?	0	1	2	3	4
5. keep a conversation going?	0	1	2	3	4
6. use an odd way of speaking?	0	1	2	3	4
7. avoid looking at people who spoke to him/her?	0	1	2	3	4
8. have trouble talking with adults?	0	1	2	3	4
9. overreact to loud noises?	0	1	2	3	4
10. focus on one subject for too much time?	0	1	2	3	4
11. seek the company of other children?	0	1	2	3	4
12. show an interest in the ideas of others?	0	1	2	3	4
13. have social problems with children of the same age?	0	1	2	3	4
14. understand age-appropriate humor or jokes?	0	1	2	3	4
15. show good peer interactions?	0	1	2	3	4

ASRS™ Short Form (2–5 Years)

Sam Goldstein, Ph.D. & Jack A. Naglieri, Ph.D.

Child's Name(ID): _____ Age: _____ Gender: M F Today's Date: ___/___/___

Parent's/Teacher's Name(ID): _____ Relation Type: Parent Teacher/Childcare Provider Other Date: ___/___/___

Childcare Setting: _____ Time Known Child: _____ Age: _____

Instructions: Read each statement that follows the phrase, "During the past four weeks, how often did the child..." then circle the number under the word that tells how often you saw the behavior. Read each question carefully then mark how often you saw the behavior in the past four weeks. Answer every question without skipping any. If you want to change your answer, put an X through it and circle your new choice. Be sure to answer every question.

During the past four weeks, how often did the child...

	Never	Rarely	Sometimes	Often	Very Frequently
1. Finish tasks?	0	1	2	3	4
2. Look at others when interacting with them?	0	1	2	3	4
3. Have trouble staying within limits?	0	1	2	3	4
4. Choose to play alone?	0	1	2	3	4
5. Have trouble getting organized?	0	1	2	3	4
6. Use an odd way of speaking?	0	1	2	3	4
7. Avoid looking at the whole picture to fully see?	0	1	2	3	4
8. Have trouble talking with adults?	0	1	2	3	4
9. Overreact to loud noises?	0	1	2	3	4
10. Focus on one subject for too much time?	0	1	2	3	4
11. Change the category of topics too often?	0	1	2	3	4
12. Show an interest in the ideas of others?	0	1	2	3	4
13. Have problems with transitions or changes in routine?	0	1	2	3	4
14. Understand a sophisticated humor or jokes?	0	1	2	3	4