



Evaluation Information Form Deafblind

Student name: _____ Date: _____

Date of birth: _____

Student's town of residence / school district: _____

Name of person completing form: _____

Relationship to student: _____

Vision Information

Blind: Yes No

Visual acuity: Right eye _____ Left eye _____ Both: _____

Field loss: _____

Low vision: Yes No

Wears glasses: Yes No

Etiology: _____

List prescribed aids (telescope, magnifier) _____

Communication / Social Skills

Hearing

Otological history: _____

Surgery: _____

Other: _____

Hearing Status: Normal Hearing loss

Degree of loss:

- Mild Moderate Moderately Severe
 Severe Profound

Type of loss:

- Conductive Sensorineural Mixed

Use of amplification:

- Monaural (one hearing aid) Binaural (two hearing aids)
 Wears consistently Wears inconsistently

Type of aid:

- Behind-the-ear In-the-ear In-the-canal
 Body aid Cochlear Implant FM system

Communication Skills (Expressive, Receptive, and Pragmatic Language)

Primary language used by student: _____

Expressive methods used (check all that apply):

- Objects Photographs Line drawings
 Facial expressions Body language Gestures
 Speech Mayer-Johnson pictures
 Sign Language Augmentative communication device

Length of utterances expressed:

- Single words Short phrases Sentences

Receptive language (used to receive information) (check all that apply):

- Objects Photographs Line drawings
 Facial expressions Body language Gestures
 Speech Mayer-Johnson pictures
 Sign Language Augmentative communication device

Length of utterances understood:

- Single words
- Short phrases
- Sentences

Follows directions:

- 1-step
- 2-step
- Multiple-step

Pragmatic language (social skills / appropriate use of language):

- Makes eye contact
- Says "hello" and "goodbye"
- Waits his/her turn
- Uses appropriate space boundaries
- Initiates conversation
- Maintains topic during a conversation

Mobility

Please check all that apply:

- Ambulatory
- Long cane
- Assistive device
- Wheelchair
- Alternative cane
- Travels stairs
- Travels independently

Level of assistance needed for mobility: _____

Additional mobility information: _____

Medical Information

Diagnoses	Limitations on Daily Activities		
	None	Slight	Significant

Height: _____ Weight: _____

Please list allergies: _____

Medical history (hospitalizations / surgery): _____

Date of last physical exam: _____

Current Medications (*List seizure medications separately in the next section.*)

Medication	Dose	Route	Time/ Frequency	Reason for Use

Does the student use any medical devices / equipment? (e.g., tracheotomy, oxygen) Yes No If Yes, please describe. _____

Seizures

Type: _____

Frequency / Duration: _____

Intensity: _____

Diastat Protocol? Yes No

Seizure Medications

Medication	Dose	Time/Frequency

Additional medical information: _____

Daily Living Skills

Toileting:

- Toilet trained
- Toilet scheduled
- Needs some assistance
- Needs total assistance
- Requires catheterization

Eating:

- Eats independently (may require adaptive equipment)
- Requires intermittent assistance and/or verbal prompts
- Requires significant assistance for safety and/or nutrition
- Food allergies: _____

Diet:

- Regular
- Therapeutic (specify): _____
- Fed by g-tube

Food consistency:

- Whole
- Cut-up
- Soft
- Chopped
- Pureed
- Mixed (specify): _____

MBS swallow study date: _____

Dressing:

- Independent
- Needs some assistance
- Needs total assistance
- Adaptive equipment: _____

Additional daily living information: _____

Behavior / Mental Health Information

Does the student display behavioral challenges? Yes No

If Yes, briefly describe behaviors. _____

Does the student have a behavior plan (please attach)? Yes No

Does the student have a mental health diagnosis? Yes No

If Yes, what is the diagnosis(es) _____

Does the student see a therapist / counselor? Yes No

If Yes, how often? _____

Educational Information

Current classroom placement:

- Fully included
- Resource room
- Private school
- Substantially separate classroom

Grade: _____

Does the student function at grade level? Yes No

If No, what is the functioning level? _____

Describe type of curriculum: _____

Support services (please include hours per day / week / month):

- Individual Aide: _____
- Occupational Therapy: _____
- Physical Therapy: _____
- Orientation & Mobility: _____
- Speech and Language Therapy: _____
- Adaptive Physical Education: _____
- Psychological Services: _____
- Adaptive Computer Instruction: _____
- Counseling: _____
- Teacher of the Visually Impaired: _____
- Teacher of the Deaf/Blind
- Music Instruction: _____

Approximate level of education performance: _____

Additional educational information: _____

Has this student been affiliated with any Perkins-related services (for example, Infant/Toddler Program, Outreach, New England Center)? Yes No

If Yes, please describe. _____
