Perkins SCHOOL FOR THE BLIND

Thank you for your interest in Perkins School for the Blind Diagnostic Evaluation Services!

To refer a student for an evaluation, the parents, school district, or other referral agent must complete and return the enclosed Perkins evaluation forms, which include the *Required Paperwork Checklist, Contact Sheet, and Evaluation Information Form,* along with all available educational, clinical, and medical records pertaining to the student. A cover letter stating your request for an evaluation, the assessments being requested, and information about who or what agency will be responsible for the cost of the evaluations should be included. Please refer to the *Required Paperwork Checklist* for all necessary application materials and use it to organize your referral packet.

Please be aware that these documents serve as your application. Without ALL of the relevant information, we will not be able to begin the review process.

The Perkins evaluation team will review the application materials once a complete packet has been received. We will contact you to discuss the team's recommendation for scheduling an evaluation.

The cost of an evaluation may vary depending on the student's specific needs and on the assessments being requested. Please refer to the *Evaluation Fees* handout for current pricing.

If you have any questions or need assistance in meeting any of the requirements please contact Susan Symons, Evaluations Coordinator in the Diagnostic Evaluation Services office at (617) 972-7571.

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Student Name

Required Paperwork Checklist

Please send <u>all</u> available educational, clinical, and medical reports. Place a checkmark in the "Enclosed" column next to each report that you include in your application packet. Place a checkmark in the "Not Enclosed" column for all reports that are not applicable or you are unable to send at this time, and briefly explain in the "Comments" column. List additional reports included under "Other." ***Please use the other side of this form to list all medical reports. <u>Please return this form with the rest of your application packet.</u>***

Report - Educational / Clinical	Enclosed	Not Enclosed	Comments
Required Paperwork Checklist			
Contact Sheet			
Completed *Evaluation Information Form*			
Current IEP or ISP			
Progress Reports			
Teacher of the Visually Impaired			
Educational			
Psychological			
Speech and Language			
Occupational Therapy			
Physical Therapy			
Orientation and Mobility			
Behavioral			
Ophthalmological			
Low Vision			
Audiological			
Social Service			
Video of the Student			
Other:			

<u>Please list all medical information on the other side.</u>

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Contact Sheet

Help us stay in touch! Please provide as much information as possible.

Student Name: _____

Parent(s) / Guardian(s)

Name(s): _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

School Contact / Other

Name and Title: _____

Affiliation: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Person Completing Form: _____

How did you hear about Perkins? _____

Would you like to receive information about special news / events? _____

If yes, by e-mail, mail, or both? _____

Please return this form with the rest of your application packet.

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Evaluation Information Form
Secondary

Student name: _____ Date: _____

Date of birth: _____

Student's town of residence / school district: _____

Name of person completing form: _____

Relationship to student: _____

Vision

Totally blind: ☐ Yes ☐ No

Partially sighted: ☐ Yes ☐ No

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

Describe other visual concerns (i.e., visual field deficits, cortical vision impairment, recent or progressive loss of vision, etc.): _____

_____

Hearing

Describe the student's hearing: _____

_____

List prescribed aids (cochlear implants, FM unit, etc.): _____

_____

List the date and location of the student's last audiology evaluation and describe the results: _____

_____

_____

_____

Speech and Language

Describe the student's receptive and expressive language: _____

Please list and describe two to three of the student's likes and dislikes. _____

List the date and location of the student's last speech and language evaluation: _

List the date and location of the student's feeding/swallow evaluation: _____

Educational Information

Type of educational placement: _____

Approximate grade level of educational performance: _____

Interests, strengths, and areas of difficulty (please describe): _____

Educational Support Services

Please check all that apply:

☐ Individual Aide: _____ ☐ Vision Teacher: _____
☐ Occupational Therapy: _____ ☐ Orientation & Mobility: _____
☐ Physical Therapy: _____ ☐ Speech/Language Therapy: _____
☐ Counseling: _____ ☐ Psychological Services: _____
☐ Adaptive P.E.: _____ ☐ Adaptive Computer Instruction: _____

Social Skills

Describe the student's social skills, relationships, and use of leisure time: _____

_____

_____

_____

_____

_____

_____

Behavior and Adjustment

Are there any behavior and adjustment concerns? _____

_____

_____

_____

_____

Describe any mental health concerns: _____

_____

_____

_____

Orientation and Mobility

Describe the student's mobility at school, home, and in the community. Include the use of mobility aids. _____

_____

_____

_____

Daily Living Skills

Describe the student's daily living skills, including eating, dressing, toileting, and use of adaptive equipment: _____

_____

_____

_____

_____

_____

_____

Medical Information

Diagnoses

Please list all: _____

_____

_____

_____

_____

Allergies

Please list all: _____

_____

_____

_____

Medical History

Please list all surgeries / hospitalizations, including psychiatric hospitalizations:

_____

_____

_____

_____

_____

Seizures

Type: _____

Frequency / Duration: _____

Intensity: _____

Current Medications (include seizure medications)

Medication	Dose/Route	Time/ Frequency	Reason for Use

Does the student use any medical devices / equipment (e.g., tracheotomy, oxygen, etc.)? _____

_____

_____

_____

_____

Additional information about the student's medical history and/or current health concerns: _____

_____

_____

_____

Has this student been affiliated with any Perkins-related services (for example, Infant/Toddler Program, Outreach, New England Center for Deaf Blind)?

☐ Yes ☐ No

If *Yes*, please describe. _____

_____

_____

Evaluation Questions and Concerns

Please list the questions you want the evaluators to consider for the evaluation:

Please list any additional or more specific concerns:

Please attach additional paper if needed.

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Evaluation Fees

Audiological	$203.00
Behavioral	$292.00
Clinical Low Vision[1]	$200-$500
Educational	$342.00
Home & Personal Management	$163.00
Occupational Therapy	$203.00
Orientation and Mobility	$245.00
Physical Therapy	$203.00
Prevocational	$245.00
Psychological	$1,169.00
Speech and Language	$271.00
Follow-Up Consulting[2]	$132.00/hour/per professional

All evaluation areas may not apply to each student.
All fees are in U.S. dollars and are subject to change.

Massachusetts school districts – please call for in-state public school rates

[1]Available through the New England Eye Low Vision Clinic at Perkins
[2]Please call the Evaluations office for more information