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

<table>
<thead>
<tr>
<th>Report - Educational / Clinical</th>
<th>Enclosed</th>
<th>Not Enclosed</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Required Paperwork Checklist</td>
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<td>Contact Sheet</td>
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<td>Completed Evaluation Information Form</td>
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<td>Current IEP or ISP</td>
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<td>Progress Reports</td>
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<td>Teacher of the Visually Impaired</td>
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<td>Social Service</td>
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<td>Video of the Student</td>
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<tr>
<td>Other:</td>
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</table>

Please list all medical information on the other side.
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.
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
Low vision: □ Yes □ No
Visual acuity: Right eye _____ Left eye _____ Both: ______
Cortical Vision Impairment (CVI) □ Yes □ No
Field loss: __________________________________________
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

Type of amplification device:
□ Hearing aid – make and model: ________________________________
□ Cochlear implant – make and model: ________________________________
□ Baha – side worn: ________________________________
□ FM system – make and model: ________________________________

Use of amplification:
□ Monaural (one hearing aid)  □ Binaural (two hearing aids)
□ Wears consistently  □ Wears inconsistently

Communication Skills (Expressive, Receptive, and Pragmatic Language)

Primary language used by student: ________________________________

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
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

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

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Limitations on Daily Activities</th>
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Height: __________________________

Weight: ________________________

Please list allergies: ____________________________________

_____________________________________________________

Medical history (hospitalizations / surgery): ____________________________

_____________________________________________________

_____________________________________________________

Date of last physical exam: ____________________________

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Time/ Frequency</th>
<th>Reason for Use</th>
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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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Time/Frequency</th>
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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:
________________________________________________________________________

________________________________________________________________________

**Adaptive Equipment**

- [ ] Seating
- [ ] Eating Utensils
- [ ] Braces
- [ ] Walker
- [ ] Stander
- [ ] Other: ____________________________

**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: ____________________
- [ ] Audiology: _________________________________
- [ ] 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. __________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
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: __________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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Please attach additional paper if needed.
### Evaluation Fees

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
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<tbody>
<tr>
<td>Audiological</td>
<td>$203.00</td>
</tr>
<tr>
<td>Behavioral</td>
<td>$292.00</td>
</tr>
<tr>
<td>Clinical Low Vision(^1)</td>
<td>$200-$500</td>
</tr>
<tr>
<td>Educational</td>
<td>$342.00</td>
</tr>
<tr>
<td>Home &amp; Personal Management</td>
<td>$163.00</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$203.00</td>
</tr>
<tr>
<td>Orientation and Mobility</td>
<td>$245.00</td>
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<tr>
<td>Physical Therapy</td>
<td>$203.00</td>
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<tr>
<td>Prevocational</td>
<td>$245.00</td>
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<tr>
<td>Psychological</td>
<td>$1,169.00</td>
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<tr>
<td>Speech and Language</td>
<td>$271.00</td>
</tr>
<tr>
<td>Follow-Up Consulting(^2)</td>
<td>$132.00/hour/per professional</td>
</tr>
</tbody>
</table>

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