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
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

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: _____

_____

_____

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:

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