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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<tr>
<td>Teacher of the Visually Impaired</td>
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<td>Audiological</td>
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<td>Social Service</td>
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<td>Video of the Student</td>
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<td>Other:</td>
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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
Early Learning Center

Student name: ___________________________ Date: ______________
Date of birth: ___________________________
Student’s town of residence / school district: ___________________________
Name of person completing form: ___________________________
Relationship to student: ___________________________

Medical Information

Birth History

Full term? □ Yes □ No If No, gestational age: _________
Complications during or following birth? □ Yes □ No
If Yes, please describe: ___________________________

______________________________________________

Did the child spend time in the NICU after birth? □ Yes □ No
If Yes, how long? ___________________________

Diagnosis: ___________________________

______________________________________________

______________________________________________
Additional Medical and Health Conditions

Check all that apply based on medical reports:

☐ Allergies (be specific): ________________________________

☐ Cerebral palsy

☐ Deaf or hearing impaired

☐ Endocrine disorder

☐ Feeding problems

☐ Heart disorder

☐ Orthopedic impairment

☐ Seizure disorder / infantile spasms

☐ Respiratory problems

☐ Medical device dependent (i.e., g-tube, oxygen, etc.)

☐ None

Other medical or health conditions: __________________________________________________________

_____________________________________________________________________________________

Date of last physical examination: __________________________________________________________

Height: __________________________ Weight: __________________________

Hospitalizations / Surgeries (list eye surgeries in vision section which follows):

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Seizures

Type: ______________________________________________________

Frequency / Duration: ______________________________________

Intensity: _________________________________________________
Current Medications

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

Primary visual diagnosis as determined by medical reports:

☐ Blind: Yes ☐ No

☐ Light Perception: Yes ☐ No

Visual Acuity (if known): Right eye _____ Left eye _____ Both: ______

Does the child use (check all that apply):

☐ Glasses (prescription and/or sunglasses)

☐ Prosthesis

☐ Contact lenses

☐ None

☐ Other low vision aids (magnifier, CCTV, telescopes)

Please list other visual aids: __________________________________________

Date of last eye exam: __________________________________________

Ophthalmologist’s name: __________________________________________
Visual behaviors (check all that apply):

- Eccentric viewing (head tilt)
- Eye pressing
- Gaze aversion
- Head shaking
- Inconsistent visual performance
- Light gazing (including finger flicking)
- Photophobic (light sensitive)
- Responds to objects only if held close
- None
- Other; please describe: ______________________________

Eye surgeries (please list with date): ______________________________

Hearing Information

Hearing test results:

- Within Normal Limits
- Not Within Normal Limits

If Not Within Normal Limits, please indicate type of loss:

- Conductive
- Sensorineural

Degree of hearing loss:

- Mild
- Moderate
- Severe
- Profound

List prescribed aids (i.e., hearing aids, cochlear implants, FM unit): ____________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
Communication Information

Primary language used by student: ____________________________________________

Please describe how your child communicates: ________________________________

_____________________________________________________________________

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

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

Expressive methods used (check all that apply):

☐ Sounds  ☐ Gestures  ☐ Body language
☐ Speech  ☐ Photographs  ☐ Sign language
☐ Objects  ☐ Mayer-Johnson pictures
☐ Facial expressions  ☐ Augmentative communication device

Length of utterances expressed:

☐ Single words  ☐ Short phrases  ☐ Sentences

Speech Intelligibility:

☐ Easily understood by others  ☐ Not understandable
☐ Understood with some difficulty

Follows directions:

☐ 1-step  ☐ 2-step  ☐ Multiple-step  ☐ Does not follow directions

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

☐ Makes eye contact / turns toward listener  ☐ Waits his/her turn
☐ Says “hello” and “goodbye”  ☐ Uses appropriate space boundaries
☐ Initiates conversation  ☐ Maintains topic during a conversation
Social-Emotional / Behavior Information

Does the child present any behavioral challenges (for example, tantrums, head banging, aggressive behaviors, difficulties with transitions, difficulties during bedtime or mealtime routines)? Please be as specific as possible.

________________________________________________________________________________________
________________________________________________________________________________________

How frequent are any behavioral challenges, and how difficult are they for you to manage?

________________________________________________________________________________________
________________________________________________________________________________________

Is there a written behavior plan?

Are there any sleep problems?

Are there specific events / conditions that cause the child to become upset?

________________________________________________________________________________________

How does the child respond to unfamiliar settings and people?

________________________________________________________________________________________

What helps to calm the child when he/she is upset?

________________________________________________________________________________________

What are the child’s most preferred activities? What does he/she typically do during free time?

________________________________________________________________________________________

How does the child interact with you?

with other adults?

with siblings?

with other children?

**Mobility Information**

Please check all that apply:

- [ ] Ambulatory
- [ ] Long cane
- [ ] Wheelchair
- [ ] Alternative cane
- [ ] Travels stairs
- [ ] Walker

Does the child use any vision while moving?  
- [ ] Yes  
- [ ] No

Does the child have any motor limitations?  
- [ ] Yes  
- [ ] No

Does the child have physical or sensory limitations which impact hand use?  

__________________________________________________________________________

How does the child move independently?  

__________________________________________________________________________

What types of environments (such as home, school, relatives’ homes) is the child exposed to?  

__________________________________________________________________________

What motivates the child to move?  

__________________________________________________________________________

Do you have specific safety concerns?  

__________________________________________________________________________

Additional information:  

__________________________________________________________________________

**Daily Living Skills**

Toileting:

- [ ] Toilet trained  
- [ ] During the day  
- [ ] During the night

- [ ] Schedule trained
- [ ] Indicates need to be changed
- [ ] Needs minor assistance
- [ ] Needs total assistance
Comments (include types of potty seats or special equipment): ____________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Eating:
☐ Eats independently (no adaptive equipment)
☐ Eats independently (may require adaptive equipment)
☐ Requires intermittent assistance and/or verbal prompts
☐ Requires significant assistance for safety and/or nutrition
☐ Food allergies (please list): __________________________________________
____________________________________________________________________________________________________________________________________

Diet:
☐ Regular
☐ Therapeutic (please specify): __________________________________________
☐ Fed by g-tube

Food consistency:
☐ Whole  ☐ Cut-up  ☐ Soft  ☐ Chopped
☐ Pureed  ☐ Mixed (specify): __________________________________________
____________________________________________________________________________________________________________________________________

Does the child use special adaptive mealtime equipment? If so, please list. ______
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________

What type of mealtime seating does the child use?
☐ Highchair  ☐ Booster  ☐ Rifton  ☐ TrippTrapp
☐ Other (please specify): __________________________________________

Dressing:
☐ Independent  ☐ Needs some assistance
☐ Needs total assistance
Adaptive equipment child uses: __________________________________________
______________________________________________________________
Additional information: ____________________________________________
______________________________________________________________

Sensory Motor Integration

How does the child respond to movement activities such as swinging, bouncing, rocking, etc.? __________________________________________

______________________________________________________________

How does the child typically respond to touch? Does he/she seem overly sensitive or unaware of touch? ________________________________

______________________________________________________________

What are the child’s favorite activities/toys? __________________________

______________________________________________________________

Educational Information

Current classroom placement:

☐ Fully included
☐ Resource room
☐ Substantially separate classroom
☐ Private school
☐ Home-based services
☐ Other
☐ Early intervention

Pre-Braille / Compensatory Skills

Does the child identify common objects? How does the child explore them?
Using his/her mouth, one or two hands? ________________________________

______________________________________________________________
Does the child functionally use toys, writing implements, paintbrushes? ____________

Does the child recognize voices and familiar environmental sounds? ____________

Does the child enjoy listening to others read stories or rhymes? ____________
Listening to audio recordings? ____________

Does the child have a favorite book? ____________

Does the child hold books and turn its pages? ____________

Does the child explore texture books? ____________

Does the child explore a variety of textures (smooth, rough, bumpy, wet scratchy)? If so, does he/she exhibit a preference or aversion to certain textures? ____________

If visual, does the child identify shapes, colors or print letters? ____________

Has the child been exposed to braille and if so, does he/she touch braille in exploration? Does he/she identify any braille letters? ____________

Does the child have experience with a braille writer? ____________

**Support Services**

If the child is receiving vision services, who provides them? (Please check all that apply and indicate hours per day / week / month.)

☐ Certified / Licensed TVI: ____________

☐ Orientation & Mobility Specialist: ____________

☐ Deaf/Blind Specialist: ____________

☐ Other: ____________
Does the child receive additional services?  (Check all that apply and indicate hours per day / week / month.)

☐ Individual Aide: ________________________________
☐ Occupational Therapy: ___________________________
☐ Orientation & Mobility: __________________________
☐ Speech and Language Therapy: ____________________
☐ Physical Therapy: ______________________________
☐ Adaptive Physical Education: _____________________
☐ Psychological Services: __________________________
☐ Computer Instruction: ____________________________
☐ Music: __________________________

Additional information: __________________________________

Has this child 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.
## 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>
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<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