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>Educational</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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</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
Lower School

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: ______________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

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 student 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: ________________________________

Receptive:  □ Understands functional directions  
□ Understands multi-step commands  
□ Within functional limits

Expressive:  □ Gestures  □ Single words  
□ Short phrases  □ Sentences

Alternative / Augmentative:
□ Objects  □ Pictures  
□ Sign language  □ Tangible symbols  
□ Augmentative devices (switches, computer, Touch ‘n Talk, other voice output devices)

**Social-Emotional / Behavior Information**

Does the student present any behavioral challenges (e.g., 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 student to become upset? __

How does the student respond to unfamiliar settings and people? _____________

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

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

How does the student interact with you? _____________________________
    with other adults? ______________
    with siblings? ______________
    with other students? ______________

**Mobility Information**

Please check all that apply:

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

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

Does the student have any motor limitations? [ ] Yes [ ] No

How does the student move independently? ____________________________

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

What motivates the student to move? ____________________________

Do you have specific safety concerns? ____________________________
**Daily Living Skills**

**Toileting:**
- ☐ Toilet trained  ☐ During the day  ☐ During the night
- ☐ Schedule trained
- ☐ Wears diapers, Attends, or pull-ups
- ☐ Needs minor assistance
- ☐ Needs total assistance

**Comments:** __________________________________________________________

**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

**Adaptive mealtime equipment:** __________________________________________

**Mealtime seating:** ____________________________________________________

**Does the student eat meals in the school cafeteria?**  ☐ Yes  ☐ No

**Diet:**
- ☐ Regular
- ☐ Therapeutic (specify): ____________________________________________
- ☐ Fed by g-tube

**Has a swallow study (MBS) ever been performed?**  If so, when and what were the results? ________________________________________________
Food consistency:

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

Food preferences: __________________________

Food allergies: __________________________

Dressing:

☐ Independent  ☐ Needs some assistance  ☐ Needs total assistance

Additional information: ________________________________________________________________

Sensory Motor Integration

Does the student have trouble sitting & paying attention to tasks? ☐ Yes  ☐ No
Does the student become upset by loud noises? ☐ Yes  ☐ No
Does the student become over stimulated in busy environments? ☐ Yes  ☐ No
Does the student become upset when they are dirty or messy? ☐ Yes  ☐ No
Does the student dislike having his/her hair or teeth brushed? ☐ Yes  ☐ No
Is the student sensitive to certain types of clothing (tags, etc.)? ☐ Yes  ☐ No
Does the student avoid eating certain tastes or textures? ☐ Yes  ☐ No
Does the student like swinging and rocking? ☐ Yes  ☐ No
Is the student constantly moving or in motion? ☐ Yes  ☐ No
Does the student like hugs, crashing on the floor, deep pressure? ☐ Yes  ☐ No

Educational Information

Current classroom placement:

☐ Fully included  ☐ Resource room  ☐ Private school  ☐ Home-based services  ☐ Substantially separate classroom  ☐ Other: ________________________________________________________________
At what grade level is the student working…

…in Reading: ________________________________
…in Math: ________________________________
…in Spelling: ________________________________
…in other areas: ________________________________

Does the student work primarily with materials in:

- [ ] Regular print
- [ ] Large print
- [ ] Braille

Does the student use a brailler?  
- [ ] Yes
- [ ] No

Does the student have computer skills?  
- [ ] Yes
- [ ] No

In what academic areas does the student show the most success? ________________________________

What academic areas are the most challenging? ________________________________

If the student is functioning below kindergarten level, what is the student’s estimated developmental level? ________________________________

Does the student identify:  
- [ ] Objects
- [ ] Shapes
- [ ] Braille letters

If visual:  
- [ ] Pictures
- [ ] Colors
- [ ] Print letters

**Support Services**

If the student 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 student 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 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: _________________________

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
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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&lt;sup&gt;1&lt;/sup&gt;</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>
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<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&lt;sup&gt;2&lt;/sup&gt;</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*

<sup>1</sup>Available through the New England Eye Low Vision Clinic at Perkins  
<sup>2</sup>Please call the Evaluations office for more information