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
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

Medication	Dose/Route	Time/ Frequency	Reason for Use

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 (s*witches, 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
- ☐ Alternative cane
- ☐ Sighted Guide
- ☐ Long cane
- ☐ Travels stairs
- ☐ Wheelchair
- ☐ Walker

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? _____

_____

Additional information: _____

_____

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:

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