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.
Required Paperwork Checklist

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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</thead>
<tbody>
<tr>
<td>Required Paperwork Checklist</td>
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<tr>
<td>Contact Sheet</td>
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<tr>
<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>Educational</td>
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<td>Ophthalmological</td>
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<td>Low Vision</td>
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<td>Audiological</td>
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<tr>
<td>Social Service</td>
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<tr>
<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.
Student name: ________________________________ Date: __________________
Date of birth: ____________________
Student’s town of residence / school district: ________________________________
Name of person completing form: ________________________________
Relationship to student: ________________________________

Vision

Totally blind: ☐ Yes ☐ No
Partially sighted: ☐ Yes ☐ No
Visual acuity: Right eye _____ Left eye _____ Both: __________
Describe other visual concerns (i.e., visual field deficits, cortical vision impairment, recent or progressive loss of vision, etc.): ________________________________

Hearing

Describe the student’s hearing: ________________________________
List prescribed aids (cochlear implants, FM unit, etc.): ________________________________
List the date and location of the student’s last audiology evaluation and describe the results: ________________________________
Speech and Language

Describe the student’s receptive and expressive language: ________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please list and describe two to three of the student’s likes and dislikes. _________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List the date and location of the student’s last speech and language evaluation: __________
________________________________________________________________________

List the date and location of the student’s feeding/swallow evaluation: __________
________________________________________________________________________

Educational Information

Type of educational placement: __________________________________________________________________________
________________________________________________________________________

Approximate grade level of educational performance: ________________
________________________________________________________________________

Interests, strengths, and areas of difficulty (please describe): ________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Educational Support Services

Please check all that apply:

☐ Individual Aide: _______________ ☐ Vision Teacher: _______________
☐ Occupational Therapy: _______ ☐ Orientation & Mobility: _____________
☐ Physical Therapy: ____________ ☐ Speech/Language Therapy: _________
☐ Counseling: _________________ ☐ Psychological Services: ___________
☐ Adaptive P.E.: _______________ ☐ Adaptive Computer Instruction: ______

Social Skills

Describe the student’s social skills, relationships, and use of leisure time: ______
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Behavior and Adjustment

Are there any behavior and adjustment concerns? ___________________________
__________________________________________________________________________
__________________________________________________________________________

Describe any mental health concerns: ___________________________
__________________________________________________________________________
__________________________________________________________________________
Orientation and Mobility

Describe the student’s mobility at school, home, and in the community. Include the use of mobility aids.

______________________________________________________________

______________________________________________________________

______________________________________________________________

Daily Living Skills

Describe the student’s daily living skills, including eating, dressing, toileting, and use of adaptive equipment.

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Medical Information

Diagnoses

Please list all:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________
Allergies

Please list all:

__________________________________________________________

__________________________________________________________

__________________________________________________________

Medical History

Please list all surgeries / hospitalizations, including psychiatric hospitalizations:

__________________________________________________________

__________________________________________________________

__________________________________________________________

Seizures

Type: _______________________________________________________

Frequency / Duration: _________________________________________

Intensity: ___________________________________________________

Current Medications (include seizure medications)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Route</th>
<th>Time/Frequency</th>
<th>Reason for Use</th>
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</table>
Does the student use any medical devices / equipment (e.g., tracheotomy, oxygen, etc.)? 

Additional information about the student’s medical history and/or current health concerns: 

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>
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<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 Vision¹</td>
<td>$200-$500</td>
</tr>
<tr>
<td>Educational</td>
<td>$342.00</td>
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<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>
</tr>
<tr>
<td>Psychological</td>
<td>$1,169.00</td>
</tr>
<tr>
<td>Speech and Language</td>
<td>$271.00</td>
</tr>
<tr>
<td>Follow-Up Consulting²</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*

¹Available through the New England Eye Low Vision Clinic at Perkins

²Please call the Evaluations office for more information