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.

Perkins
SCHOOL FOR THE BLIND

____
Student Name

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.***

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:			

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

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

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

Evaluation	Fee
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