

REQUEST FOR SERVICE  
**STUDENT EVALUATION/CONSULTATION**  
 TAZEWELL-MASON COUNTIES SPECIAL EDUCATION ASSOCIATION  
 300 Cedar St., Pekin, IL 61554-2576  
 Phone: 309/347-5164 Fax: 309/346-0440

<u>EVALUATIONS</u>	<u>CONSULTATIONS</u>
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> ADOS  <input type="checkbox"/> AUDIOLOGY  <input type="checkbox"/> CAP  <input type="checkbox"/> EDUCATIONAL/BEHAVIORAL  <input type="checkbox"/> FUNCTIONAL VISION ASSESSMENT  <input type="checkbox"/> OCCUPATIONAL THERAPY  <input type="checkbox"/> PHYSICAL THERAPY                 </div> <div style="width: 35%; text-align: center;"> <b><u>LOW INCIDENCE EVALUATION</u></b>  <input type="checkbox"/> INITIAL  <input type="checkbox"/> RE-EVALUATION  <input type="checkbox"/> SCHRAMM                 </div> </div>	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> ADAPTIVE P.E.  <input type="checkbox"/> ASSISTIVE TECHNOLOGY  <input type="checkbox"/> AUTISM  <input type="checkbox"/> EDUCATIONAL/BEHAVIORAL STRATEGIES  <input type="checkbox"/> FUNCTIONAL CURRICULUM                 </div> <div style="width: 35%;"> <input type="checkbox"/> HEARING  <input type="checkbox"/> OCCUPATIONAL THERAPY  <input type="checkbox"/> PHYSICAL THERAPY  <input type="checkbox"/> SATELLITE/SCHRAMM  <input type="checkbox"/> VISION                 </div> </div>

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

SCHOOL DISTRICT: \_\_\_\_\_ ATTENDING SCHOOL: \_\_\_\_\_

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

PRIMARY LANGUAGE: \_\_\_\_\_ MODE OF COMMUNICATION: \_\_\_\_\_

MEDICAID # (If eligible): \_\_\_\_\_

SPECIAL EDUCATION SERVICES:     YES     NO    504 SERVICES:     YES     NO

IF YES, CURRENT PROGRAM: \_\_\_\_\_

PRIMARY DISABILITY OR MEDICAL DIAGNOSIS: \_\_\_\_\_

RELATED SERVICES: \_\_\_\_\_

DESCRIBE HOW THE CHILD'S PROBLEM(S) ADVERSELY IMPACTS HIS/HER EDUCATIONAL PROGRAM: \_\_\_\_\_

DESCRIBE WHAT INTERVENTION STRATEGIES HAVE BEEN ATTEMPTED AND WITH WHAT RESULTS: \_\_\_\_\_

PERSON REQUESTING SERVICES: \_\_\_\_\_ DATE: \_\_\_\_\_

DISTRICT SPECIAL EDUCATION ADMINISTRATOR: \_\_\_\_\_ DATE: \_\_\_\_\_

**Signature Required**

CONTACT PERSON FOR SCHEDULING: \_\_\_\_\_

CONTACT PERSON'S PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

**CHECK ONE:**

PARENT NOTIFICATION OF CONSULTATION    DATE PARENT/GUARDIAN NOTIFIED: \_\_\_\_\_

PARENT CONSENT FOR EVALUATION (**ATTACH**)    DATE PARENT/GUARDIAN SIGNED: \_\_\_\_\_

*Evaluations will be completed and sent to district within 60 school days from date of parent consent. Consultation includes up to three IDEA funded visits with one report.*

**\*If evaluation reports are needed prior to 60 school day timeline indicate anticipated date of IEP meeting \_\_\_\_\_**