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

EVALUATIONS		**CONSULTATIONS**	
☐ AUDIOLOGY	**LOW INCIDENCE EVALUATION**	☐ ADAPTIVE P.E.	☐ IEP FACILITATION
☐ AUTISM EVALUATION	☐ INITIAL	☐ ASSISTIVE TECHNOLOGY	☐ OCCUPATIONAL THERAPY
☐ EDUCATIONAL/BEHAVIORAL	☐ RE-EVALUATION	☐ AUTISM	☐ ORIENTATION & MOBILITY
☐ FUNCTIONAL VISION ASSESSMENT	☐ SCHRAMM	☐ EDUCATIONAL/BEHAVIORAL STRATEGIES	☐ PHYSICAL THERAPY
☐ MEDICAL REVIEW		☐ FUNCTIONAL CURRICULUM	☐ SCHRAMM
☐ OCCUPATIONAL THERAPY		☐ HEARING	☐ TRANSITION
☐ ORIENTATION & MOBILITY (O&M)			☐ VISION
☐ PHYSICAL THERAPY			

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________**

NAME:______________________________ DOB:______________ Gender ☐ M ☐ F

PARENT/GUARDIAN:______________________________ PHONE:______________

ADDRESS:______________________________ E-MAIL:______________________

SCHOOL DISTRICT:______________________ ATTENDING SCHOOL:______________________

TEACHER:__________________ GRADE:______ BEST TIME TO VISIT__________(IF ECE ☐ AM OR ☐ PM)

PRIMARY LANGUAGE:______________________ MODE OF COMMUNICATION:______________

MEDICAID: ☐ YES ☐ NO HAVE PARENTS GIVEN CONSENT TO BILL MEDICAID & IS IT ON FILE: ☐ YES ☐ NO

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 <u>AND</u> WITH WHAT RESULTS:

PERSON REQUESTING SERVICES:______________________________ DATE:______________

DISTRICT SPECIAL EDUCATION ADMINISTRATOR:______________________________ DATE:__________

Signature <u>Required</u>

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:______________

All Student Requests should be sent to to Kari Behrends @ kbehrends@tmcsea.org.