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

- ☐ AUDIOLOGY
- ☐ AUTISM EVALUATION
- ☐ EDUCATIONAL/BEHAVIORAL
- ☐ FUNCTIONAL VISION ASSESSMENT
- ☐ MEDICAL REVIEW
- ☐ OCCUPATIONAL THERAPY
- ☐ ORIENTATION & MOBILITY (O&M)
- ☐ PHYSICAL THERAPY

LOW INCIDENCE EVALUATION

- ☐ INITIAL
- ☐ RE-EVALUATION
- ☐ SCHRAMM

CONSULTATIONS

- ☐ ADAPTIVE P.E.
- ☐ ASSISTIVE LISTENING EQUIPMENT
- ☐ ASSISTIVE TECHNOLOGY
- ☐ AUTISM
- ☐ EDUCATIONAL/BEHAVIORAL STRATEGIES
- ☐ FUNCTIONAL CURRICULUM
- ☐ HEARING
- ☐ IEP FACILITATION
- ☐ OCCUPATIONAL THERAPY
- ☐ ORIENTATION & MOBILITY
- ☐ PHYSICAL THERAPY
- ☐ SCHRAMM
- ☐ SATELLITE ED PROGRAM
- ☐ TRANSITION
- ☐ VISION

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 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:_____

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