

___	Psychoeducational Evaluation
___	Conference ___ Yes ___ No
___	Neuropsychological Evaluation
___	Conference ___ Yes ___ No
___	Risk Evaluation
___	Conference ___ Yes ___ No
___	Social/Emotional/Personality Evaluation
___	Conference ___ Yes ___ No
___	Speech/Language Evaluation
___	Audiological Evaluation
___	Central Auditory Processing Evaluation
___	Other (specify)

Clinic Referral Form
Confidential

DATE _____

STUDENT'S NAME _____

D.O.B.: _____ AGE: _____ MALE FEMALE

NAME OF PARENT OR GUARDIAN: _____ RELATIONSHIP: _____
(IF STUDENT HAS A GUARDIAN OR IS IN CUSTODY OF DYS, PLEASE ATTACH COURT ORDER)

HOME ADDRESS _____ TOWN _____ ZIP CODE _____

HOME TELEPHONE _____ WORK TELEPHONE _____ CELL # _____

REFERRING DISTRICT: _____
(The referring school district is responsible for payment)

PERSON COMPLETING FORM: _____ SCHOOL: _____
(Should be person making referral)

WOULD YOU LIKE TO SPEAK WITH CLINICIAN? YES NO

Position: _____ E-Mail: _____ Phone: _____

Teacher: _____ Grade: _____

HAS THE CHILD BEEN SEEN AT R.E.A.D.S. PREVIOUSLY? YES NO
IF YES, WHEN?: _____

Does student currently attend a READS program? YES NO (If yes, please check below)

CID HOLD DHH READS ACADEMY Other: _____

Will an interpreter be needed for the student? YES NO Describe: _____

Will an interpreter be needed for the parents? YES NO Describe: _____

School will provide interpreter. R.E.A.D.S. will provide interpreter.

Referral Paperwork Checklist

- | | |
|--|---|
| ___ Signed Parental Consent and Release Form | ___ Completed Developmental History Questionnaire |
| ___ Reason for Referral Form | ___ Teacher Assessment Form |
| ___ Massachusetts School Health Record | ___ Prior test results or medical records |
| ___ Any available completed rating scales | |

READS, INC.

DATE: _____

STUDENT NAME: _____

CURRENTLY ON IEP: YES NO *Please enclose last accepted IEP.*

1. **REASON FOR REFERRAL:** Including overview of school progress, statement of current standing, and **issues to be addressed**. List specific questions and concerns.

2. **EDUCATIONAL HISTORY:** Please complete or attach updated **EDUCATIONAL ASSESSMENT PART A.**

GRADE:

SCHOOL:

TOWN:

3. **PREVIOUS EVALUATIONS:** (INCLUDE COPIES IF AVAILABLE)

DATE:

EVALUATOR:

4. **ACADEMIC RECORDS:** Please include all academic records Kindergarten to present. **(Report cards and/or transcript)**

5. **MENTAL HEALTH** - Is there evidence to suggest emotional or mental health factors may be affecting student's performance? (If so, please describe.)

READS, INC.

TEACHER ASSESSMENT

DATE: _____

STUDENT'S NAME: _____

TEACHER'S NAME: _____ PHONE: _____

SUBJECT(S): _____

- ◆ Description of current placement and how are services being provided.

- ◆ Briefly comment on the student's academic functioning or achievement.

- ◆ Other

Behavioral Adjustment: excellent good fair poor

Attentional Capacity: excellent good fair poor

Motor Coordination: excellent good fair poor

Activity Levels and Pattern: normal area of concern

Communication Skills: excellent good fair poor

Memory: Long Term excellent good fair poor

Short Term excellent good fair poor

Social Relationships:

Groups normal area of concern

Peers normal area of concern

Adults normal area of concern

If concerns are noted, please explain;

PARENT RELEASE
(MEMBER DISTRICTS ONLY)

This form is to be attached to the Developmental History Questionnaire. Please complete all portions of this referral packet. If you are in need of assistance, please contact your child's school.

_____ (Student's name) _____ (Referring District)

PARENTS MUST ACCOMPANY THE STUDENT TO R.E.A.D.S. ON THE INITIAL VISIT.

I, as a parent or guardian, hereby give consent for R.E.A.D.S. to conduct any *medical* and/or *psychoeducational evaluation(s)* on the above named child. I understand that the results of these evaluations will be shared with the public school named above. I give consent for the R.E.A.D.S. staff to review any school records as deemed necessary to carry out the requested evaluation(s). I also give the READS staff permission to take a Polaroid photograph of my child, to be included in the student's file for the purpose of identification.

_____ (Date) _____ (Signature) _____ (Relationship)

In addition, I give permission to the staff at R.E.A.D.S. to contact my family physician for relevant medical information.

Physician name: _____
Street Address: _____
City/Town: _____
State/Zip Code: _____
Phone: (_____) _____

_____ (Date) _____ (Signature) _____ (Relationship)

I give my permission to the staff of R.E.A.D.S. to contact my child's most *recent therapist* or *out-of-school counselor* (if any) named below in the interest of obtaining relevant information.

Therapist or Counselor: _____	Therapist or Counselor: _____
Street Address: _____	Street Address: _____
City/Town: _____	City/Town: _____
State/ Zip Code: _____	State/ Zip Code: _____
Phone: (_____) _____	Phone: (_____) _____

_____ (Date) _____ (Signature) _____ (Relationship)

MEDICAID INFORMATION

If your child is eligible for Medicaid, *please* complete all of the information on this form and *bring* your *Medicaid or Mass Health card* with you on your first visit.

If the child's name is spelled incorrectly on the Medicaid card, please write it on this form identical to the spelling on the card and then make a note on the bottom of this form indicating the correct spelling.

_____	_____	_____
(Last Name)	(First Name)	(Middle Initial)

- - - - -		
(Card Holder's Number)		

_____	_____	_____
(Student's Number)	(Eligibility Date: From	To)

_____	()	_____
(Medicaid Office Town)		(Medicaid Office Phone)

My child is not eligible for Medicaid. (Please check if your child is not on Medicaid.)

DEVELOPMENTAL HISTORY QUESTIONNAIRE

DATE _____

NAME OF CHILD/ADOLESCENT _____

QUESTIONNAIRE COMPLETED BY _____ RELATIONSHIP _____

Welcome to R.E.A.D.S. Collaborative. It is important that you complete the attached *Developmental History Questionnaire* and the age appropriate *Supplemental Questionnaire Form* prior to your scheduled visit. The information you provide enables us to service your individual needs. We are grateful for your assistance in this process and share your concern for your child's well being and academic success. Please call us if you are in need of further explanation or assistance.

**I HAVE THE FOLLOWING CONCERNS REGARDING MY CHILD'S EDUCATIONAL,
EMOTIONAL AND/OR SOCIAL WELL BEING;**

1. _____
2. _____
3. _____
4. _____

MY CHILD HAS STRENGTHS AND TALENTS IN THE FOLLOWING AREAS;

1. _____
2. _____
3. _____
4. _____

PREGNANCY HISTORY

MOTHER BEGINS REGULAR PRE-NATAL CARE AT _____ MONTHS. MOTHER'S AGE AT TIME OF DELIVERY IS _____ YEARS.

THIS IS MOTHER'S _____ PREGNANCY (INCLUDE LIVE BIRTHS, STILLBORN AND MISCARRIAGE).

_____ LIVE BIRTHS _____ MISCARRIAGE _____ STILLBORN BIRTH _____ CESAREAN DELIVERIES

PREGNANCY WAS uncomplicated

PREGNANCY WAS complicated

- HIGH BLOOD PRESSURE
- DIABETES
- TOXEMIA
- SERIOUS INJURY OR ACCIDENT
- VAGINAL BLEEDING IN _____ MONTH
- X-RAYS OR ULTRASOUND IN _____ MONTH
- INFECTION (explain) _____
- MOTHER SMOKED CIGARETTES (_____ PER DAY)
- MATERNAL ALCOHOL USE (_____ DAILY)
- MATERNAL DRUG USE
 - PRESCRIPTION _____
 - NON-PRESCRIPTION _____
 - OTHER _____

Physician Comment : _____

BIRTH HISTORY

DATE OF BIRTH _____ MALE FEMALE PLACE OF BIRTH _____

BIRTH WEIGHT _____ LBS. _____ OZ. SINGLE BIRTH MULTIPLE BIRTH _____

- FULL TERM PREGNANCY
- PRE-TERM PREGNANCY _____
- POST-TERM PREGNANCY _____
- CHILD IS ADOPTED
- FOSTER CHILD
- OTHER _____
- LABOR WAS SPONTANEOUS
- LABOR WAS INDUCED

DELIVERY WAS uncomplicated

DELIVERY WAS NORMAL (NVD)

DELIVERY WAS complicated

- DELIVERY WAS BY FORCEPS
- DELIVERY WAS BREECH
- DELIVERY WAS BY CESAREAN SECTION
- RH PROBLEM _____
- CORD AROUND NECK _____
- INFANT JAUNDICE
 - OTHER _____
- INFANT REQUIRES RESUSCITATION

- INFANTS APGAR SCORE IS ____/____
- I DO NOT KNOW APGAR SCORE
- INFANT RECEIVES STANDARD NURSERY CARE
- INFANT PLACED IN NEO-NATAL OR INTENSIVE CARE NURSERY
- INFANT IS BREAST FED
 - TOLERATES WELL
 - DOES NOT TOLERATE WELL _____
- INFANT IS FORMULA FED
 - TOLERATES WELL
 - DOES NOT TOLERATE WELL _____

Physician Comment : _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ TELEPHONE(_____)_____

PHYSICIAN'S ADDRESS: _____

WHEN DID YOUR CHILD LAST SEE A MEDICAL DOCTOR ? _____ REASON: _____

ALLERGY; NONE KNOWN SEASONAL ENVIRONMENTAL FOOD PET/ANIMAL MEDICINES _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS ? (IF YES, PLEASE CHECK AND EXPLAIN BELOW)

- Grid of 30 medical conditions with checkboxes: CHICKEN POX, MEASLES, GERMAN MEASLES, MUMPS, WHOOPING COUGH, SCARLETINA, RHEUMATIC FEVER, HEART MURMUR, CHEST PAIN, ASTHMA, ALLERGY, ARTHRITIS/JOINT REDNESS, HEAD INJURY, CONCUSSION, SEIZURE DISORDER, LOSS OF CONSCIOUSNESS, HEADACHE/MIGRAINE, EYE PROBLEMS/INJURY, EAR INFECTIONS, HEARING LOSS, DIFFICULTY BALANCING, DENTAL PROBLEMS, DIFFICULTY SWALLOWING, DIFFICULTY WITH SPEECH, RECURRING SORE THROAT, STREP/STAPH INFECTION, SLEEP DISORDER, MONONUCLEOSIS, PNEUMONIA, BRONCHITIS, SKIN DISEASES; ECZEMA, ACNE, DIABETES, HEPATITIS, KIDNEY DISEASE OR INJURY, BLOOD DISEASE, STOMACHACHES, CONSTIPATION, FREQUENT DIARRHEA, UNUSUAL WEIGHT GAIN/LOSS, BONE FRACTURES, SCOLIOSIS, LEAD EXPOSURE

PLEASE EXPLAIN: _____

HOSPITALIZATIONS:

DATE: _____
NAME OF HOSPITAL: _____
ADDRESS: _____
TOWN/CITY/STATE: _____
REASON: _____

DATE: _____
NAME OF HOSPITAL: _____
ADDRESS: _____
CITY/TOWN/STATE: _____
REASON: _____

ACCIDENTS (OTHER THAN MINOR CUTS AND BRUISES): _____

EMOTIONAL TRAUMA OR PROBLEM: _____

PSYCHOTHERAPY OR COUNSELING:

DATE: _____
NAME: _____
ADDRESS: _____
TOWN/CITY: _____
TELEPHONE: _____

DATE: _____
NAME: _____
ADDRESS: _____
TOWN/CITY: _____
TELEPHONE: _____

SPECIAL EVALUATIONS, STUDIES OR TESTING (INCLUDES GENETIC ANALYSIS)

TEST DATE: _____
LOCATION: _____
ADMINISTERED BY: _____
REASON: _____
RESULTS: _____

TEST DATE: _____
LOCATION: _____
ADMINISTERED BY: _____
REASON: _____
RESULTS: _____

Physician Comment : _____

CURRENTLY, CHILD TAKES THE FOLLOWING SUPPLEMENTS OR MEDICINES ON A REGULAR BASIS;

PRESCRIPTION

NON-PRESCRIPTION

CHILD HAS TAKEN ANTIBIOTICS IN THE PAST. NO YES,TYPE AND REASON _____

CHILD LAST SAW A DENTIST ON _____, FOR (REASON) _____.

CHILD IMMUNIZATION RECORDS ARE UP TO DATE. YES NO UNSURE; _____
(Physician, please review School Immunization Record)

Physician Comment : _____

GROWTH AND DEVELOPMENT

CHILD SAT FREE AT _____ MONTHS.

CHILD WAS TOILET TRAINED AT _____ MONTHS.

CHILD WALKED ALONE AT _____ MONTHS.

CHILD KNEW COLORS AT _____ YEARS.

CHILD SPOKE SINGLE WORDS AT _____ MONTHS.

CHILD KNEW LETTERS AT _____ YEARS.

CHILD'S DEVELOPMENT WAS; AVERAGE COMPARED TO PEERS SLOWER THAN PEERS MORE ADVANCED THAN PEERS
CHILD'S ACTIVITY LEVEL WAS; AVERAGE COMPARED TO PEERS SLOWER THAN PEERS MORE ACTIVE HYPERACTIVE
CHILD'S ATTENTION SPAN WAS; AVERAGE COMPARED TO PEERS SHORTER THAN PEERS LONGER THAN PEERS

CHILD IS RIGHT HANDED LEFT HANDED AMBIDEXTROUS; _____

SLEEP HISTORY; CHILDHOOD NIGHTMARES NIGHT TERRORS TALKS IN SLEEP SLEEPWALKS
 DIFFICULTY FALLING ASLEEP DIFFICULTY STAYING ASLEEP GRINDS TEETH SLEEPS RESTLESS SLEEPS WELL
COMMENTS: _____

CHILD DEVELOPED SECONDARY SEX CHARACTERISTICS AT ____ YEARS. (GIRLS: BREAST DEVELOPMENT; BOYS: PUBIC HAIR)
CHILD HAS BEGUN MENSTRUATION. NO YES; PLEASE PROVIDE ADDITIONAL INFORMATION REQUESTED
DATE OF FIRST MENSTRUAL PERIOD WAS _____. DATE OF LAST MENSTRUAL PERIOD IS _____.
CYCLES ARE REGULAR IRREGULAR
 WITH LITTLE OR NO DISCOMFORT OR CRAMPING CRAMPING,BLOATING,DISCOMFORT

CHILD STARTED NURSERY SCHOOL AT _____ YEARS OF AGE. CHILD STARTED KINDERGARTEN AT _____ YEARS OF AGE.
CHILD STARTED FIRST GRADE AT ____ YEARS OF AGE. CHILD REPEATED GRADE(S) ____, ____, ____, ____.
CHILD IS CURRENTLY IN GRADE ____.
CHILD; ENJOYS SCHOOL EXPERIENCE DOES NOT LIKE SCHOOL BECAUSE _____
_____.

CHILD HAS HOBBIES OR INTERESTS NO YES; _____
CHILD PARTICIPATES IN SPORTS NO YES; _____
CHILD PARTICIPATES IN SCHOOL ORGANIZATIONS/CLUBS; NO YES; _____
CHILD PARTICIPATES IN COMMUNITY ORGANIZATIONS; NO YES; _____

Physician Comment : _____

SOCIAL HISTORY

CHILD CURRENTLY LIVES AT HOME OTHER (SPECIFY) _____

CHILD RESIDES IN THE CARE OF (PLEASE CHECK APPROPRIATE BOXES BELOW);

- | | | |
|--|--|---|
| <input type="checkbox"/> BIOLOGICAL MOTHER | <input type="checkbox"/> ADOPTIVE FATHER | <input type="checkbox"/> FOSTER FAMILY |
| <input type="checkbox"/> BIOLOGICAL FATHER | <input type="checkbox"/> STEP FATHER | <input type="checkbox"/> RELATIVE _____ |
| <input type="checkbox"/> ADOPTIVE MOTHER | <input type="checkbox"/> STEP MOTHER | <input type="checkbox"/> OTHER _____ |

RESIDENTIAL PROGRAM _____

LANGUAGE SPOKEN AT HOME IS ENGLISH OTHER _____

SIBLINGS NO YES; (PLEASE COMPLETE BELOW)

NAME	DATE OF BIRTH	RESIDENCE	EDUCATION	HEALTH

WHO IS SPENDING MOST TIME WITH CHILD ? _____

METHOD OF DISCIPLINE MOST OFTEN USED IS _____

CHILD/ADOLESCENT SMOKES CIGARETTES. NO YES; _____ PPD

CHILD/ADOLESCENT EXPERIMENTS WITH MARIJUANA. NO YES; OCCASIONALLY DAILY WEEKENDS ONLY

CHILD/ADOLESCENT EXPERIMENTS WITH ALCOHOL. NO YES; OCCASIONALLY DAILY WEEKENDS ONLY

CHILD/ADOLESCENT EXPERIMENTS WITH HARD DRUGS. NO YES; OCCASIONALLY DAILY WEEKENDS ONLY
SUBSTANCE OF CHOICE IS _____ UNKNOWN

HAS CHILD/ADOLESCENT BEEN INVOLVED WITH THE POLICE, LEGAL OR CORRECTIONAL AUTHORITIES (INCLUDES TRUANCY)?

NO YES; EXPLAIN _____

IS CHILD/ADOLESCENT CURRENTLY PROHIBITED BY LAW FROM BEING IN THE COMPANY OF MINOR CHILDREN WITHOUT SUPERVISION? NO YES; EXPLAIN _____

Physician Comment : _____

FAMILY MEDICAL HISTORY

MOTHER'S NAME:	FATHER'S NAME:
DATE OF BIRTH: AGE:	DATE OF BIRTH: AGE:
PLACE OF BIRTH:	PLACE OF BIRTH:
EDUCATION:	EDUCATION:
OCCUPATION:	OCCUPATION:
HEALTH:	HEALTH:

GRANDPARENTS	HEALTH	IF DECEASED, CAUSE OF DEATH
MATERNAL GRANDMOTHER		
MATERNAL GRANDFATHER		
PATERNAL GRANDMOTHER		
PATERNAL GRANDFATHER		

IF YOUR CHILD OR RELATIVE HAS ANY OF THE FOLLOWING DISORDERS, PLEASE CHECK THE APPROPRIATE BOX AND IDENTIFY THE RELATIONSHIP OF THAT INDIVIDUAL TO THE CHILD IN THE SPACE PROVIDED.

<input type="checkbox"/> ECZEMA, ASTHMA , HAYFEVER	<input type="checkbox"/> HEART DISEASE
<input type="checkbox"/> ALLERGY TO MEDICINE	<input type="checkbox"/> DIABETES
<input type="checkbox"/> BONE OR JOINT PROBLEMS	<input type="checkbox"/> LUNG DISEASE
<input type="checkbox"/> CANCER	<input type="checkbox"/> THYROID DISEASE OR ABNORMAL BODY SIZE
<input type="checkbox"/> BLOOD DISEASE	<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> BIRTH DEFECTS; INCLUDES MENTAL RETARDATION, AUTISM AND CEREBRAL PALSY	<input type="checkbox"/> SEIZURES, CONVULSIONS OR EPILEPSY
<input type="checkbox"/> TUMORS	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> PSYCHIATRIC DISORDER	<input type="checkbox"/> LEARNING DISABILITY OR SCHOOL PROBLEMS
<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> SUBSTANCE ADDICTION
<input type="checkbox"/> HEARING PROBLEM	<input type="checkbox"/> VISION PROBLEM

PLEASE TAKE A MOMENT TO SHARE ANY ADDITIONAL INFORMATION ABOUT YOUR CHILD/ADOLESCENT THAT YOU FEEL MAY BE HELPFUL IN UNDERSTANDING AND RESPONDING TO THEIR PARTICULAR NEED. YOUR INSIGHT IS EXTREMELY BENEFICIAL.

Physician Comment : _____
