

___	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 | |