Region 14 - Hopewell Center
Consultation/Evaluation Referral Packet
For Children 3 to 22 Years Old

Please use this packet to request the following Hopewell services:

- Motor Evaluation (Adapted Physical Education, Occupational Therapy, Physical Therapy)

Please:

1. **Provide the information listed,**
2. **Provide the child's name and date of birth below,**
3. **Please indicate if student has been identified with a disability,**
4. **Please indicate if student is on an IEP or 504, if so please attach,**
5. **Sign below,**
6. **Send this page along with all information listed for the Motor Evaluation (Adapted Physical Education, Occupational Therapy, Physical Therapy) you are requesting.**
7. **Send to Region 14 - Hopewell Center attention Mary Hiler**

I am requesting Region 14 - Hopewell Center provides the service(s) indicated below for;

______________________________ ______________________

Child's Name Date of Birth

Motor Evaluation

- Copy of Referral for Evaluation (Form PR-04) if this is an initial evaluation.
- Permission to Evaluate – **Enclosed**, page 4
- Motor Evaluation Information (Preschool or School-Age)

Please indicate if student is P/S or School Age, type of referral & due date:

____ ***Preschool*** ____ ***School Age***

- ☐ **Transition Meeting** **due date** ________
- ☐ **Initial Evaluation** **due date** ________
- ☐ **Re-evaluation** **due date** ________

Has student been identified with a disability? ____ **Yes** ____ **No**
Is student on an IEP? ____ **Yes** ____ **No**
Is student on a 504 ? ____ **Yes** ____ **No**

______________________________ ______________________ ____________

District Contact Person Signature District Date

PR-04 REFERRAL FOR EVALUATION

CHILD'S INFORMATION

NAME: ______________ ID NUMBER: ______________
STREET: ______________ GENDER: ______ GRADE: ___
CITY: ______________ STATE: OH ZIP: ______
DATE OF BIRTH: ______________

BUILDING OF CURRENT ATTENDANCE: ______________
TEACHER(S): ______________
STUDENT'S NATIVE LANGUAGE (if not English): ______________

PARENTS' / GUARDIAN INFORMATION

NAME: ______________
STREET: ______________
CITY: ______________ STATE: OH ZIP: ______
HOME PHONE: ______________ WORK PHONE: ______________
CELL PHONE: ______________ EMAIL: ______________

PARENT'S NATIVE LANGUAGE (if not English): ______________

Reason for Referral:

EDUCATIONAL HISTORY

Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development:

Provide data from previous interventions, including interventions required by rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

Number of school districts attended: ____

Years at present school building: ______

List schools/early childhood programs and dates:

ATTENDANCE:

☐ Regular ☐ Irregular

Is this student age-appropriate for grade level? ☐ Yes ☐ No

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with ☐ Vision ☐ Hearing
Does the student ☐ Wear Glasses ☐ Use hearing aid(s)

PR-04 REFERRAL FOR EVALUATION

Does the student take medication ☐ Yes ☐ No

Does the student have any health/developmental/physical problems of which you are aware? ☐ Yes ☐ No

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school

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For Preschool Children Only *(please check the area(s) of concern):*

- ☐ Eating
- ☐ Receptive Communication
- ☐ Cognitive
- ☐ Vision
- ☐ Other
- ☐ Dressing
- ☐ Expressive Communication
- ☐ Fine Motor
- ☐ Social/Emotional Behavior
- ☐ Toileting
- ☐ Hearing
- ☐ Play
- ☐ Attention
- ☐ Gross Motor

Describe any other pertinent information not previously described:

SIGNATURES

Signature of Person Initiating the Referral	Signature of Person Receiving the Referral
Position or Relationship to Student	Title
Date	Date Received
	Date District Suspects a Disability

Region 14 - Hopewell Motor Evaluation
Pre-school or School Age

Name: ______________________ Date of Birth: ______________

District: __________________ School: __________________ Grade: _____

Please check service area(s) for which you are requesting an evaluation. A physical therapy evaluation will require a doctor's prescription ***or*** permission from parent to forward P.T. evaluation to Doctor (on permission to consult page).

_____ Occupational Therapy

- ___ Fine Motor skills
- ___ Sensory/Attention Issues
- ___ Handwriting
- ___ Self Care in school setting
- ___ Feeding/Oral Motor
- ___ Adaptive Equipment

_____ Physical Therapy

- ___ Gross Motor Skills
- ___ Walking/Balance
- ___ Stair Climbing
- ___ Positioning in school
- ___ Wheelchair mobility
- ___ Wheelchair needs
- ___ Adaptive Equipment

_____ Adaptive Physical Education

- ___ Gross Motor Skills of P.E.
- ___ Modification/Adaptations for P.E.
- ___ Adaptive Equipment Recommendations

What is your main concern for this student:

____

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____

_____ Permission to evaluate child for therapy services.

I further understand and agree that the information collected by the school district will then be reviewed and the team will develop an intervention plan and designate the resources needed to implement these interventions.

____
Name of Parent/Guardian

____
Signature of Parent/Guardian

____
Date