

Evaluation Report

NAME: PARENTS/GUARDIAN:
ADDRESS: PHONE:
SCHOOL/DIST: REFERRAL SOURCE:
SCHOOL ADDRESS: CONTACT PERSON:
SCHOOL PHONE: PROGRAM PLACEMENT:
DATE: AGE/DOB:

DIAGNOSIS:

COGNITIVE FUNCTIONING LEVEL:

A/AC CASE MANAGER:
PHONE:

TEAM MEMBERS:

I. BACKGROUND INFORMATION

- A. Medical:
- B. Family:
- C. School:
- D. Previous A/AC systems:

II. REFERRAL CONCERNS

III. ASSESSMENT PROCEDURES

IV. DISCUSSION

Points to consider:

V. SUMMARY OF EVALUATION/RECOMMENDATIONS