

Date of ARD \_\_\_\_\_

La Joya Independent School District  
Special Education Department  
Request for Evaluation

- Initial
- Reevaluation
- Special Request by ARD
- Other

CAMPUS: \_\_\_\_\_

DIAGNOSTICIAN: \_\_\_\_\_

DUE DATE FOR EVALUATION: \_\_\_\_\_

TO: \_\_\_\_\_

Type of Evaluation:

<input type="checkbox"/> Speech (Part C)	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Adaptive PE	<input type="checkbox"/> <b>OT Prescription</b>	<input type="checkbox"/> <b>PT Prescription</b>
<input type="checkbox"/> Psychological (ED or AU)	<input type="checkbox"/> Psychiatric (OHI)	<input type="checkbox"/> Counseling
<input type="checkbox"/> Eye Medical	<input type="checkbox"/> Audiological/Otological	<input type="checkbox"/> OHI type: _____
<input type="checkbox"/> Comprehensive Educational	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Assistive Technology ( <b>Attach the ATD Referral Form</b> )		

Please conduct the following evaluation(s) on:

Student: \_\_\_\_\_ ID# \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Physical Address : \_\_\_\_\_  
 Parents Name: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_  
 Secondary Phone Number: \_\_\_\_\_  
 \*Doctors Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 \*ATTACH:  
 Notice for Release/Consent to Request Confidential Information (with Parents Signature)  
 \*\* If student has Medicaid please provide Medicaid Number \_\_\_\_\_  
 **Medicaid Consent Form with Parent Signature**

Check Handicaps:

<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Medically Fragile
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Autism	<input type="checkbox"/> Other Health Impairment	<input type="checkbox"/> Orthopedic Impairment
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Deaf/Blind	<input type="checkbox"/> Auditory Impairment
<input type="checkbox"/> Multiple Disabilities			

Comments:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Office Use Only:  
 Date Received: \_\_\_\_\_  
 Date Processed: \_\_\_\_\_