

SCREENING

REQUEST

FORM

CHILD'S NAME _____ M F DOB _____

SS# _____ MEDICAID? N Y # _____

PARENTS NAME _____ SCHOOL DISTRICT: _____

ADDRESS _____ CITY _____ ZIP _____

PHONE _____ CELL OR EMERGENCY PHONE _____

LANGUAGE SPOKEN IN HOME? _____ TRANSLATOR FOR PARENTS? Y N

PRESCHOOL PROGRAM _____ TEACHER _____ PH# _____

CHILD ENROLLED IN: _____ HEAD START _____ ABC _____ DAYCARE _____ PRESCHOOL _____ NONE

I GIVE PERMISSION FOR NORTHWEST ARKANSAS EDUCATION SERVICE COOPERATIVE TO SCREEN MY CHILD. I GIVE PERMISSION FOR SCREENING, EVALUATION, AND TREATMENT RECORDS TO BE DISCLOSED TO AUTHORIZED PERSONNEL OF NWAESC FOR THE PURPOSE OF EVALUATION AND ESTABLISHMENT OF A TREATMENT PROGRAM, IF APPROPRIATE.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PARENT COMPLETES TOP PORTION ONLY

TO BE COMPLETED BY SCREENING STAFF:

DIAL 4 SCREENING DATE _____	CHILD'S SCORE _____	7% (1.5 SD) CUTOFF _____	
MOTOR	_____	_____	INTELLIGIBILITY:
CONCEPTS	_____	_____	
LANGUAGE	_____	_____	_____ GOOD
SELF-HELP	_____	_____	_____ OK
SOCIAL	_____	_____	_____ POOR

OTHER SCREENING INSTRUMENT: _____ **SCORES:** _____

HEARING: _____ **PASS FAIL** **VISION:** _____ **PASS FAIL**

BEHAVIOR CONCERNS: N Y * **IF YES, EXPLAIN BELOW AND ATTACH ANY DOCUMENTATION**

ANY OTHER CONCERNS? _____

- PROGRAM DIRECTIONS:**
1. PARENT COMPLETES TOP SECTION
 2. TEACHER COMPLETES BOTTOM SECTION
 3. SEND TO CENTRAL OFFICE
 4. MAIL OR FAX COPY TO 479-267-5965

REC'D DATE: _____

RECOMMENDATION: ___PASS___REFER___RESCREEN