



EDUCATIONAL SERVICES UNIT

Burlington County Special Services School District
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www.edservicesunit.com

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2018 - 2019 CHILD STUDY TEAM REQUEST EVALUATIONS & MEETINGS

Student's Name

NJ SID#:

C.A.

DOB:

Student's Address:

Home Phone:

Parent(s) Name:

Work Phone:

District of Residence:

School Attending: Grade/Class Type: Classification:

Case Manager: Teacher:

Case Manager Phone: Email:

Contact Person to Schedule Testing:

Contact Person Phone: Email:

Evaluation(s) Requested: (Check all that apply) Psychological Learning Social

(Specify tests, i.e. WIAT, WJ, WISC, WPPSI, WAIS):

CST Services: Meeting Initial Evaluation Re-evaluation (Specify time/s, date/s, and location/s below)

MUST ATTACH EVALUATION PLAN TO ALL REQUESTS

Reason for Referral:

Describe interventions that have been attempted to address the problem:

Describe the student's current academic functioning:

Do you require the evaluator at the IEP conference? YES__ NO__ NOTE: District will be billed for IEP conference time.

Please check any special considerations: prescription medications__ eyeglasses__ hearing aids
Other: Please explain

Child Study Team Director Signature Date

PLEASE ATTACH ANY OTHER RELEVANT INFORMATION

Educational Services Unit Use Only

Assignment Date:
FAX#: 609-702-9033/ bvermes@burlcoschools.org
ATTN: Brooke Vermes, Public CST Supervisor

Evaluator:
Evaluation Sent to District: