EDUCATIONAL SERVICES UNIT

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Burlington County Special Services School District
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DEAF & HARD OF HEARING CHILD STUDY TEAM

EVALUATION REQUEST FORM

Student Name:	**School District:**
NJ SID #:	**Case Manager:**
Classification:	**Phone Number:**
DOB:	**Fax Number:**
School Attending:	**Case Manager Email:**
Grade:	**CST Director:**
Student Address:	**CST Director Email:**
Student City, State & Zip:	**Primary Language in the home:**
Parent Name:	**Primary Language of student:**
Parent Email:	**Work Phone:**
Projected Evaluation Results Meeting Date:	**Home Phone:**

CST Service Requested:	☐	**INITIAL EVALUATION**	☐	**RE-EVALUATION**
***Evaluation(s) Requested*:**	☐	**LEARNING**	☐	**PSYCHOLOGICAL**
	☐	**SPEECH/LANGUAGE**	☐	**SPEECH/LANGUAGE & ARTICULATION**

The following are required for all Evaluation requests:

Parental Consent Form ☐Attached **Audiogram ☐Attached** **IEP (if applicable) ☐Attached**

Please note, we cannot process a request without the submission of the above

Amplification	
☐ Personal Hearing Aids _____(Age first aided) ☐ Personal FM System ☐ Classroom Soundfield System	
Cochlear Implant	
☐ Cochlear Implant: ☐ Right ☐ Left	Age of Implantation: .
Current Support	
☐ Educational Interpreter* Frequency:	☐ Teacher of the Deaf Frequency:
☐ Requires Interpreter for Evaluation*	☐ Educational Audiologist Frequency:

If one or more is checked, we will provide a Comprehensive D/HH trained Educational Interpreter to be present during testing.
NOTE: We do not provide interpreters for district provided evaluators.

Primary Area(s) of concern:

If all three evaluations are requested, it is our practice is to have the SLP conduct record review and observation. If agreed, please initial ____
Upon receipt of the request for evaluation, a questionnaire will be forwarded to district to be sent to parent(s)/guardian(s).

Do you require the evaluator(s) at the Results Meeting(s)? (*If so, district will be billed for IEP conference time*) ☐**YES** ☐**NO**

(NOTE: For in county districts requesting all three evaluations, attendance at the Results Meeting is included, along with an hour follow-up TOD consultation)

_____ _____
CST Director Signature **Date**

Send Completed Request to: Fax #609-534-2066 or ESUDHHCST@burlcoschools.org **Phone #: 609-702-0500 x7401**

ESU Office Use Only: Assignment Date: _____ **Evaluation(s) Sent to District:** _____
SLP: _____ **Psych:** _____ **LDTC:** _____ **Ed I:**_____