



**Deaf and 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 of student:
Parent Name:		Parent Email:
Home #:	Work #:	Projected Results Meeting Date:

Required Documents

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 all the above documents.

Services Requested

Evaluation Type:		Evaluation(s) Requested:	
<input type="checkbox"/>	Initial Evaluation	<input type="checkbox"/>	Learning
<input type="checkbox"/>	Re-Evaluation	<input type="checkbox"/>	Psychological
Evaluators to attend Results Meeting <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	Speech Language <input type="checkbox"/> Plus Articulation

Additional Information Required

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* Teacher of the Deaf Educational Audiologist

**Our D/HH Child Study Team Educational Interpreter will be present during testing. We do not provide interpreters for district provided evaluators.*

Primary Area(s) of concern:

If all three evaluations are requested, it is our practice to have the Speech Language Pathologist conduct record review and observation. If you are NOT in agreement, please initial _____. Upon receipt of request for an evaluation, a questionnaire will be forwarded to district to be sent to parent(s)/guardian(s).

CST Director Signature

Date