EDUCATIONAL SERVICES UNIT
ESU

Educational Services Unit
Burlington County Special Services School District
20 Pioneer Blvd.
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(609) 702-0500

Dr. Ashanti Holley
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Assistant Superintendent
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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:_____ **Evaluator:**_____
Evaluation Sent to District: _____

EMAIL TO: esupubliccst@burlcoschools.org

Please note that the evaluations will be signed digitally by our evaluators unless otherwise requested.