Cardinal Glennon

Patient Label

Knights of Columbus Developmental Center

To Be Filled Out by Teacher/Therapist

Knights of Columbus Developmental Center Teacher/Therapist Package

Teachers and/or Therapists, we appreciate your time and input, as this is an important component of the evaluation process. Please fill out all applicable information.

Introduction

Child's Name: _____

Date of Birth: _____/_____/_____ **Gender**: ☐ Male ☐ Female

Date entered school: _____

Current Date: _____

Schools Name and Mailing Address: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Fax Number: _____

Teachers/Therapists Name: _____ **Phone Number**: _____

Current Classroom/Treatment Setting

Daycare ___ **Preschool** ___ **Head Start** ___ **Home Schooling** ___ **Regular/Typical Class** ___ **Vocational Training** ____
Regular/Typical Class with Resources ___ **Early childhood Special Education Classroom** ___
Autism Class ___ **First Steps** ___ **Child and Family Connections** ___ **Therapy Clinic Setting** ____ **Counseling** ____

Therapy/Special Education Services

Speech Therapy _____ min/weekly
Language Therapy _____ min/weekly
Augmentative Communication _____ min/weekly
Social Skills Training _____ min/weekly
Occupational Therapy _____ min/weekly
Physical Therapy _____ min/weekly
ABA/Discrete Trial ____ min/weekly
Denver Model ____ min/weekly
Music Therapy ____ min/weekly
1:1 Aide: full time/part time
504 Accommodation Plan: yes/no
Tutoring _____ min/weekly
Other Resources _____

Behavioral Concerns:

1. Please describe any concerns you have regarding this child's behavior:

   _____
   _____
   _____

2. Please describe any concerns you have regarding impulsivity, attention, and/or hyperactivity:

   _____
   _____
   _____

3. Please describe any symptoms of depression and/or anxiety this child displays:

   _____
   _____
   _____

Academic Skills:

Please rate this child's academic skills;

Reading Fluency/Decoding above average/average/below average
Reading Comprehension above average/average/below average
Spelling above average/average/below average
Math above average/average/below average

Social Skills:

4. Please describe any concerns you have regarding this child's social skills:

_____
_____
_____
_____
_____

Does this child engage in:
Solitary Play ____ Interactive Play ____ Parallel Play ____ Does this child have friends: yes/no
Do they attempt to interact with other children: yes/no Is the child ever teased by other children: yes/no

Motor/Adaptive Functioning Skills

5. Please describe any concerns you have regarding this child's gross motor skills:

_____
_____
_____

6. Please describe any concerns you have regarding this child's fine motor skills:

_____
_____
_____

7. Please list any sensory issues you have observed:

_____
_____
_____

8. Does this child:
Feed Themselves ___ Take care of own toileting needs ___ Dress themselves ___ Use too much force___
Brush hair/teeth without difficulty ___ Regulate their behavior (age appropriately)___

Speech and Language Skills

9. Please describe any concerns you have regarding this child's receptive language skills:

_____
_____
_____
_____

10. Please describe any concerns you have regarding this child's expressive language skills:

_____
_____
_____
_____

11. Please describe any concerns you have regarding this child's articulation skills/clarity of speech/apraxia of speech:

_____
_____
_____
_____

12. Please describe any concerns you have regarding this child's conversational/pragmatic skills:

_____
_____
_____
_____

13. Please describe any concerns you have regarding this child's written language skills:

_____
_____
_____
_____

Testing Completed

Date of Most Recent IEP:_____ Educational Diagnosis:_____

1. Please list most recent testing administered in the following areas:

Tests Administered	Date	Results
IQ/Cognitive Testing:		
Educational Testing:		
Adaptive Functioning Testing:		
Speech/Language Evaluation:		
Occupational Therapy Evaluation		
Physical Therapy Evaluation:		
Autism Evaluation:		
Other:		