HANCOCK COUNTY SCHOOLS

REQUEST FOR DIAGNOSTIC ASSESSMENT PRIOR TO REFERRAL FOR TESTING

Student _____ School _____

DOB _____ Age_____ Grade_____

Parent/Guardian _____ Phone _____

Mailing Address _____

Referring Teacher _____
(print name) *(signature)*

The 2 or 3 areas checked below indicate concerns or the SAT team. In order to obtain further information regarding your child's performance we are requesting your permission to do the following diagnostic assessments:

Rating Sheets:	Processing	Achievement:
___ ADHD	___ Auditory	___ Basic Reading
___ Aspergers	___ Visual	___ Phonological Awareness
___ Autism	___ Visual Perceptual	___ Phonemics
___ Behavior/Emotional	___ Motor	___ Rapid Naming
___ Executive Functioning	___ Listening	___ Reading Comprehension
___ Social Skills	___ Hearing	___ Reading Fluency
___ Behavioral Observation	___ Speech	___ Math
___ Autism Observation	___ Writing	___ Giftedness

___ I give permission to assess ___ Do not assess my child

_____

Parent/Guardian Signature *Date*

_____

Student Signature *Date*