**Request for Additional Evaluations**

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| **Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discipline: \_\_\_\_\_\_\_\_\_\_ Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Request for additional : 🞎 Psych 🞎SPED 🞎 ST 🞎PT 🞎OT Evaluation****Request for : 🞎 Nutrition 🞎 SW Services** |
| 1. CURRENT FUNCTIONING: (Outcomes worked on and met. Child’s response to services)
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| 1. CONCERNS/REASON FOR REQUEST (Explain the request for an additional evaluation. Use specific examples)
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| 1. RATIONALE FOR REQUEST (Why does the child need this evaluation? Include the statement if parent agree with recommendations)
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| Therapist’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |