

MEMORANDUM FOR TESTING

PUBLIC SCHOOLS OF ROBESON COUNTY-DEPARTMENT OF EXCEPTIONAL CHILDREN

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

School: _____ **PowerSchool #:** _____

MOST RECENT ACTION(S)

- Initial**
 Parental Referral (area of current eligibility _____)
 Reevaluation
 Transfer from within NC
 Transfer from Outside of the State/Country
 TBI (Traumatic Brain Injury)
 ESL (Lang. survey, LEP Plan, ACCESS, WIDA, etc.)
 Additional Testing is being requested _____

Out of State Transfer Referral Notification Date _____ **Out of State IEP End Date** _____

Comparable Services Plan Consultation Date _____ **Comparable Services Plan Start Date** _____

Referral Date (Parent or MTSS (circle one))

EVALUATION

Compliance Area Form Included and Everything Filled out/Notes	Compliance Area Form Included and Everything Filled out/Notes
Initial Evaluation (Eligibility Determination)	Reevaluation – Review of existing data
<input type="checkbox"/> Memorandum for testing	<input type="checkbox"/> Memorandum for testing
<input type="checkbox"/> School-Age Referral	<input type="checkbox"/> Reevaluation Determination
<input type="checkbox"/> Consent	<input type="checkbox"/> Consent
<input type="checkbox"/> PWN and Minutes	<input type="checkbox"/> Eligibility Determination (Copy of previous assessment)
<input type="checkbox"/> Teacher Observations and Narratives	<input type="checkbox"/> PWN and Minutes
<input type="checkbox"/> Completed Social History	<input type="checkbox"/> Teacher Observations and Narratives
<input type="checkbox"/> Health Screening	<input type="checkbox"/> Completed Social History
<input type="checkbox"/> Current grades and attendance	<input type="checkbox"/> Health Screening
<input type="checkbox"/> Progress Monitoring	<input type="checkbox"/> Current grades and attendance
<input type="checkbox"/> OT/PT Screening/Evaluation (only if requested)	<input type="checkbox"/> Progress Monitoring
	<input type="checkbox"/> OT/PT Screening/Evaluation (only if requested)

***Please ensure that ALL forms are appropriately ordered and completed or the testing packet will be returned to the EC Chairperson.**
NOTES:

ACCOUNTABILITY

Your signature affirms that the testing packet has been completed and is ready for testing submission to the Central Office EC Department.

____ Testing Packet Case Manager	Printed Name	Signature/Date
____ EC Chairperson	Printed Name	Signature/Date
____ School Principal	Printed Name	Signature/Date
____ Program Specialist	Printed Name	Signature/Date

INTEROFFICE

Date received from School (EC Department Secretary): _____ **School Psychologist Assignment Date:** _____

Date Testing Completed: _____ **School Psychologist's Signature:** _____

Date submitted to school by School Psychologist: _____

Signature/Title of Person Receiving Packet at School: _____ **Date:** _____

COMMENTS

