DATE COMPLETED_________________

# Gwinnett County Public Schools
## Early Childhood Program
## SPECIAL EDUCATION EVALUATION REFERRAL QUESTIONNAIRE
# GENERAL INFORMATION

Child's Name: ______________________________________________________________ Date of Birth: _______________Age: ________
(First) (Middle) (Last)
Sex: (circle) Male Female

Please answer **both parts** of this two-part question.

1. Is the child Hispanic or Latino? (Circle one) No, not Hispanic/Latino Yes, Hispanic/Latino
2. Please select child's race(s) from the list below (Circle one or more that apply)
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or Other Pacific Islander
   - White

Home Address: ________________________________________________________________________________
(Street) (City) (Zip)
Home Phone Number: __________________ Neighborhood Elementary School: _________________________
Referred by: _________________________________________Relationship: __________________________________
Address: ____________________________________________Phone Number: ________________________________
Person filling out form: (circle) Mother Father Stepmother Stepfather Other: ____________________________

Reason for referral (describe what concerns you most about your child and your reason for referral):
_____________________________________________________________________________________________________________
Describe your child's current difficulties_______________________________________________________________________________
How long has the problem(s) been of concern to you? __________________________________________________
When was the problem first noticed? __________________________________________________________________________________
Has your child been diagnosed with any syndromes or medical conditions: Yes No If yes, please list or describe:
_____________________________________________________________________________________________________________
Does you child attend: _____Daycare _____Preschool _____Governor's Pre-K ____Head Start _____Early Intervention Program/BCW__________
Name/Address/Phone # of the above: _______________________________________________________________

# HOME AND FAMILY INFORMATION

Mother's Name: ____________________________________ Age: _______ Education: ________________________
Occupation: _________________________Home Phone #: ________________Work Phone #: __________________
Cell Phone #: ________________
E-Mail Address: _______________________ PREFERRED MEANS OF COMMUNICATION________________
( ____Biological _____Adoptive _____Step _____Foster _____ Guardian_____)
Father's Name: ____________________________________ Age: _______ Education: _______________________
Occupation: _________________________Home Phone #: ________________Work Phone #: _________________
Cell Phone #: ________________
E-Mail Address: _______________________
( ____Biological _____Adoptive _____Step _____Foster _____ Guardian_____)
Stepparent's Name: _________________________________ Age: _______ Education: _______________________
Occupation: _________________________Home Phone #: ________________Work Phone #: _________________
Cell Phone #: ________________
E-Mail Address: _______________________ PREFERRED MEANS OF COMMUNICATION________________
Child lives with: (circle) Both parents Mother Father Other _____________________
Marital Status of Parents: (circle) Married Separated Divorced Widowed Single
If parents are separated or divorced, how old was the child when this occurred? ________________________
Primary language spoken in the home: ________________________________________
Other languages spoken in the home: _________________________________________
Is email ok to communicate with you?____________
Primary language spoken by the child________________
Is an interpreter needed for parent__________; for child____________. What language_____________

List all people currently living in the household:

| *Name* | *Relationship to the child* | *Age* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

If any brothers or sisters are living outside the home, list their names and ages: ________________________________

Please check any condition that any member of the immediate family has had. Please note the member's relationship to the child.

| *Condition:* | *Relationship to the child:* |
|---|---|
| _____ Learning Problems | ________________________ |
| _____ Speech/Language Disorder | ________________________ |
| _____ Attention Deficit Disorder | ________________________ |
| _____ Hearing or Vision Impairment | ________________________ |
| _____ Other ( ) | ________________________ |

## EARLY INTERVENTION SERVICES

Did your child receive Babies' Can't Wait Services? ( circle one) YES No ( If yes, list services?)

BCW Service Coordinator ______________________________ Phone: _____________________________________

| Service | Therapist Name | Presently Involved | No Longer Involved | Hrs/ per wk |
|---|---|---|---|---|
| Speech | __________ | __________ | __________ | __________ |
| Occupational Therapy | __________ | __________ | __________ | __________ |
| Physical Therapy | __________ | __________ | __________ | __________ |
| Special Instruction | __________ | __________ | __________ | __________ |

## PREGNANCY/BIRTH HISTORY:

**During pregnancy:**
**Were there any complications during pregnancy/birth? If yes, please indicate:**

**YES NO**

Yes No Did mother experience problems with: _____chronic disease _____poor nutrition _____vaginal bleeding _____toxemia _____viral infection _____trauma _____premature labor _____hypertension _____gestational diabetes _____other ___________________________________

Yes No Was mother on medication?
(If yes, describe: ______________________________)

Yes No Did mother smoke?

Yes No Did mother drink alcoholic beverages?

Yes No Did mother use drugs?
(If yes, please list: ______________________________)

Yes No Were forceps used during delivery?

Yes No Was a vacuum suction used during delivery?

Yes No Was a Cesarean Section performed?

Yes No Was the child breech (feet first)?

Yes No Was the child premature?

Yes No If so, how many weeks? ______________

Yes No If yes, please describe: ______________________________________________

Birth Weight: __________________

Yes No Was baby discharged with mother?
If no, how long was the baby hospitalized? _________________

Yes No Were there any feeding/swallowing problems?

If yes, please describe: ____________________

Yes No Were there any sleeping problems:

If yes, please describe: ____________________

Yes No Were there any special problems during the first few years of life?

If yes, please describe: ____________________

## DEVELOPMENTAL HISTORY

The following is a list of infant and preschool behaviors. Please indicate the age at which your child demonstrated each of the following.

| *Behavior* | *Age* | *Behavior* | *Age* |
|---|---|---|---|
| Rolled over | _____ | Fed Self | _____ |
| Sat alone | _____ | Dressed Self | _____ |
| Crawled | _____ | Became toilet trained | _____ |
| Walked alone | _____ | Stayed dry at night | _____ |
| Babbled | _____ | | |
| Put several words together | _____ | | |

## MEDICAL/ HEALTH INFORMATION

Please circle any of the following that child has or had in the past.

| | | |
|---|---|---|
| Allergies | Chronic Headaches | Anemia |
| Craniofacial Deformities | Pneumonia | Reflux |
| CMV | Cerebral Hemorrhage | Croup |
| Diabetes | Chronic Colds | Diphtheria |
| Chronic Ear Infections | Ear Tubes/ Surgery | Seizures |
| Encephalitis | Heart Problems | Fevers Over 104 Degrees |
| Head Injuries /concussion | Bleeding Disorder | Tonsillitis |
| Vocal Nodules | | Meningitis |

List any additional operations, hospitalizations or injuries your child has had and at what age:

____________________ _____

____________________ _____

Does your child use any assistive/adaptive devices? _____glasses _____braces _____walker/crutches _____wheelchair _____hearing aide _____other: (please specify: ____________________)

Please list any medication your child is presently taking:

| *Medication* | *Dosage* | *Reason for Taking* |
|---|---|---|
| | | |
| | | |
| | | |

## MEDICAL/OTHER SERVICE PROVIDERS

Pediatrician ____________________ Phone: ____________________

Cardiologist ____________________ Phone: ____________________

Neurologist ____________________ Phone: ____________________

Gastroenterologist ____________________ Phone: ____________________

ENT ____________________ Phone: ____________________

Orthopedist ____________________ Phone: ____________________

Psychologist/Psychiatrist ____________________ Phone: ____________________

Ophthalmologist ____________________ Phone: ____________________

## MOTOR DEVELOPMENT

Yes No Does your child have difficulty with walking, balance, stairs, jumping. If yes, please explain.____________________

Yes No Does your child have difficulty with coordination?

Yes No Does your child use a wheelchair/walker?

Yes No Is your child able to stack blocks, hold a crayon or marker; copy simple lines/shapes; able to manipulate puzzle pieces and small toys?

# COMMUNICATION

Do you have concerns about your child's communication development?
Explain: ______________________________________________

______________________________________________________________

My child:
Yes No Gestures/points instead of using words
Yes No Uses Babbling ( ex. baba, dada ) , jargon ( sounds like real words but are not)
Yes No Is difficult to understand? for family , unfamiliar people
Parent understands child's speech : none some about half most all
Yes No Uses words to communicate?
How many (circle) 0, 1-10, 10-20, 20-50, 50-100, more than 100
Yes No Uses phrases or sentences to communicate.
Circle: 2 word phrases, 3 word phrases, 4 word phrases, 5+ word phrases
Yes No Answers questions with words circle: who?, what?, where?, yes/no ?
Yes No Tells about a recent activity/event (ie: "I fell down.", " I saw dog.")
Yes No Points to pictures in a book on request.
Yes No Answers questions about a story?
Yes No Follows simple directions
Yes No Tell what is happening in a picture.
Yes No Speech appeared to develop and then stopped.
Yes No Does your child stutter? Is there a family history of stuttering problems? Yes No
Yes No Is your child's voice usually hoarse/ raspy?
How does your child communicate his wants and needs most often? ______________________________.
How do your child's communication difficulties affect their daily life/ or participation in daycare?
______________________________.
What strategies have you used to improve these skills? ______________________________.

# SOCIAL

Yes No Do you have concerns about your child's socialization?
Yes No Does your child enjoy being around other children?
Yes No Does your child tolerate others in his personal space?
Yes No Does your child take turns when playing with others?
Yes No Does your child follow directions related to his/her daily routine at home or school?
Yes No Does your child get frustrated easily?
Yes No If "yes", what behaviors occur? ( ie. Tantrums, refusal to participate? ______________________________

______________________________________________________________

How often?______________________
When does your child usually get frustrated? ______________________________
Yes No Does your child experience anxiety ( ie. Worry, bites nails, thumb sucks)?
If "yes", please describe: ______________________________

______________________________________________________________

Yes No Does your child have difficulty paying attention?
Yes No Is your child aggressive toward others (ie. physical and/ or verbal aggression)
If "yes", please describe______________________________
Yes No Is cruel to animals
Yes No Difficulty with changes in routines
Yes No Highly sensitive to sounds
Yes No Highly sensitive to textures
Yes No Mouths toys frequently
Yes No Biting
Yes No Seeks out rocking, spinning, swinging
Yes No Head banging
What things have you tried to help your child with these behaviors ?______________________________

______________________________________________________________

Please list your child's strengths or what you enjoy about your child or what pleases you. Favorite activities or things to do at home.

______________________________________________________________

______________________________________________________________

# COGNITION

Yes No Do you have any academic concerns ?
explain______________________________________________________________________________
_____________________________________________________________________________________

Yes No Does your child appear to be learning preschool concepts ( big/small) (more/less) ; prepositions?
Yes No Does your child appear to be learning rote preschool concepts ( colors, numbers, shapes)?

---

***Please include copies of any therapy reports or evaluations which might be helpful in our evaluation of your child.***

---

**Once you are ready to submit all necessary documents please do so the following:**

**Mail:**

**Gwinnett County Public Schools**
Department of Special Education/ Early Intervention Program
Bldg 200
437 Old Peachtree Rd., N.W.
Suwanee, GA 30024

**Fax:**
Fax: 678-301-6663

**Email:**
ECP@gcpsk12.org