**Date of Report:** **Reason for Evaluation**:

**FULL AND INDIVIDUAL EVALUATION**

**RELATED SERVICES**

**Student Name**: **Grade:** 3  **Local ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Campus of Enrollment:**  **Date of Birth:** **Medicaid#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROFESSIONAL EVALUATORS**:

**REASON FOR REFERRAL:**

**[[1]](#endnote-1)Present levels of educational performance which identify the need for the related service. “Need not be addressed for transportation only.):**

Interpersonal Skills

Attention and Concentration:

Self Esteem:

Work Habits:

Emotional Regulation:

Task Completion:

Evaluation Results:

Yes No \*Assessment data indicate that this student meets district eligibility requirements and needs the specified related service(s) to benefit from instruction

xxxxxxx

|  |  |  |  |
| --- | --- | --- | --- |
| **RELATED SERVICE(S)** | **TYPE**  **DIRECT/CONSULT** | **FREQUENCY** | **DURATION** |
| Psychological Services |  |  |  |
| Psychological Services |  |  |  |
| Psychological Services |  |  |  |

Location-where will service be provided?

Direct Services: Frequency and Amount of time

How long will each session be (minutes) and how many sessions will be held over the course of what time frame?

How much time and how many sessions over the course of what time frame will indirect services be provided?

Yes No Recommended goals and objections to be implemented by related services personnel are included.

xx

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\*Name \*Position

Measurable Goals

Timeframe

Condition

Behavior

Criteria

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Signature of Registered/Licensed/Certified Evaluator

1. Denotes required items.

   ^ Related services not listed in federal regulations or State Board of Education rules may be provided with the written approval of the Texas Education Agency. [↑](#endnote-ref-1)