

Please fax to Melanie Mazur, (812) 855-5561

INDIANA UNIVERSITY SPEECH-LANGUAGE CLINIC
BILINGUAL EVALUATION REQUEST FORM

Child's name: _____
School corporation: _____

DOB: _____
grade: _____

School name: _____
Address: _____
Phone: _____

School SLP name: _____
SLP phone #: _____
Best time to contact: _____
E-mail: _____
Fax: _____

Parents' names: _____

_____ Initial eval _____ Speech only
_____ Re-eval _____ Multi

Address: _____
Phone: _____
Parents' language(s): _____

Date you need the report: _____
60th day: _____
Days no school coming up: _____

Language(s) of evaluation: _____

Best time(s) to come test: _____
Student's lunch/recess: _____

Time school starts: _____
Time school ends: _____

Please attach a copy of your consent to exchange information and consent to evaluate

Please answer the following questions, or provide a copy of the domain page of the IAP.

Vision screened? ____pass ____fail Hearing screened? ____pass ____fail
Mo./yr. _____ Mo./yr. _____

Is the student receiving ELL services? ____yes ____no

Are there any.....

Intellectual/Academic concerns:

Motor skills concerns:

Social concerns:

Adaptive behavior concerns:

Communication concerns:

MM only: date rec'd _____

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MM only: date rec'd _____