WARREN COUNTY SCHOOLS
Exceptional Children Programs

REFERRAL FOR TESTING
RE-EVALUATION

Reevaluation determination meetings should be scheduled 90 days prior to the reevaluation due date!

School: ____

Name (Please Print): ______________________________________

SIMS #: ____

Date of Birth: _________ Teacher: ___________________________

Grade: ________ Placement: ________ Date Parental Permission: ________

Re-Evaluation Due Date: __________

☒ Needed Assessment Areas:

☐ Vision ☐ Hearing/Audiological ☐ Speech/Language
☐ Intellectual Functioning ☐ Physical/Motor ☐ Adaptive Behavior Functioning
☐ Occupational Therapy ☐ Physical Therapy ☐ Behavioral/Emotional Functioning
☐ Academic/Pre-Academic/Developmental Achievement
☐ Other (please specify):____

COMMENTS:

This form must be filled out *completely* and given to the Exceptional Children Director with a copy of the DEC 7, previous DEC 3, and DEC 2 forms in order to begin the assessment process.