

BRUSH COUNTRY CO-OP

Request for Evaluation by Co-op Diagnostician

To Be Completed/Submitted to Brush Country Co-op Director at least **4 weeks** prior to date needed

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

School District: _____ Campus: _____

Parent's Name: _____ Phone #: _____

Current Disability: _____ FIE Due Date: _____ Consent Date (initial): _____

Type of Evaluation Requested:

☐ Initial Evaluation ☐ 3 Year Re-evaluation ☐ Special ARDC Request

Attach copies of following required documentation with this request:

- ☐ Signed Consent for Evaluation: include Consent: Psychological Evaluation/Services *(if applicable)*
- ☐ Completed Referral Packet for an Initial or REED document indicating *Special request/Re-evaluation*
- ☐ Previous *Psychological Evaluation* and/or Medical information *(if applicable)*
- ☐ District diagnostician's current ARD and Testing Schedule

Justification for Request *(why District Diagnostician is unable to complete this student's evaluation):*

Diagnostician's Signature: _____ Date: _____

Campus Administrator's Signature: _____ Date: _____

BCC Director's Signature: _____ Date: _____

- ☐ Request approved.
- ☐ Request rejected. Comments: _____