Please fax to Andrea Arends, 866-981-1874 https://sphs.indiana.edu/clinics-and-services/bilingual/index.html

INDIANA UNIVERSITY SPEECH-LANGUAGE CLINIC
BILINGUAL EVALUATION REQUEST FORM

Child's name:_____ DOB:_____
School corporation: _____ grade: _____

School name: _____ School SLP name: _____
Address: _____ SLP phone #:_____
_____ E-mail:_____
Phone: _____ Fax: _____

Name of person requesting (if not SLP):_____ Parents' names: _____
Phone of requester:_____ Address: _____
E-mail of requester:_____ _____
Fax of requester:_____ Phone: _____

Language(s) of evaluation: _____ _____ Initial eval _____ Speech only
Date you need the report:_____ _____Re-eval _____Multi
Days no school coming up:_____

Best time(s) to come test:_____ Time school starts:_____
Student's lunch/recess: _____ Time school ends:_____

Unless otherwise indicated, the report will be sent to the requester at the school's address.

Please attach a copy of your consent to exchange information with IU/consent to evaluate.

Please answer the following questions, or provide a copy of paperwork addressing these questions.

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:

AA only: date rec'd_____