

DIAGNOSTIC EVALUATION APPLICATION COVER SHEET*PLEASE PRINT*

NAME: _____ DATE: _____
ADDRESS: _____ SOC. SEC. #: _____
CITY: _____ HOME PHONE: _____
STATE: _____ WORK PHONE: _____
ZIP: _____ CELL PHONE: _____

NAME OF REFERRING INSTITUTION: _____
NAME OF REFERRING SERVICE PROVIDER: _____

DIRECTIONS TO STUDENT:

1. Complete the attached confidential Self Report and the Acknowledgement of Responsibility and Release of Information Agreement.
2. If you have previously had any kind of evaluation by a psychologist, psychiatrist, physician, or educational consultant, include a copy of the report.
3. Submit all application papers to your service provider along with a check for \$125 made out to the appropriate Regional Center.

STUDENT CONFIDENTIAL SELF REPORT

Please answer the questions in brief responses so staff can identify particular areas and concerns.
The information you provide will remain confidential.

PRESENT PROBLEM

How would you describe your difficulties in learning?

In what specific areas of academic work do they appear?

BACKGROUND INFORMATION

1. List other family members living in your home now.

Name	Age	Relationship	Highest Educational Degree

2. List any members of immediate family no longer living at home (deceased, separated, away at school, etc.).

Name	Age	Relationship	Highest Educational Degree

3. Have any members of your immediate or extended family had leaning problems? Yes No
 If yes, please explain: _____

4. Is English your second language? Yes No

If yes, what is your primary language? _____

At what age did you learn English? _____

5. Marital status: Divorced Married Single Widowed

6. What kind of jobs have you held?

7. Have you ever received or are now receiving psychological or psychiatric help? Yes No

If yes, please provide the information requested below:

Name of Professional: _____

Title _____

Address: _____

Phone number: _____

Name of Professional: _____

Title _____

Address: _____

Phone number: _____

HEALTH HISTORY

1. What is the status of your general health now?

2. Was it ever suggested that you might have an attention deficit disorder? Yes No

If yes, please explain: _____

3. Have you been prescribed medication for long periods of time? Yes No

If yes, please explain: _____

4. Do you recall particular problems in any of the following areas:

(If any are checked, please explain)

Hearing _____

Vision _____

Speech _____

Language development _____

Coordination _____

Emotional development _____

EDUCATIONAL HISTORY

1. List of schools attended beginning with pre-school.

SCHOOL	DATES ATTENDED	DEGREEE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Did you ever receive special education services and/or tutorial assistance in school? Yes No
 If yes, please explain: _____

3. Were your ever retained? Yes No

If yes, list grade(s): _____

4. What was your attendance history throughout school?

5. Do you learn better by looking at information (visual learner) or do you learn better by hearing about information (auditory learner)?

6. What or who “helped:” you a great deal as you think back through your years of schooling?

7. If available, SAT scores: Math _____ Verbal _____

8. Please rate your school experience by placing a check mark (✓) under the appropriate heading.

School Years	Very Easy	Moderately Easy	Not Easy
Elementary School	_____	_____	_____
Middle School	_____	_____	_____
High School	_____	_____	_____
Post High School	_____	_____	_____

9. What do you think would help you to be more successful in your schoolwork?

10. Please rate your STUDY HABITS by checking an answer. Do you USUALLY or NEVER...

- | | | |
|--|----------------------------------|--------------------------------|
| Plan for your writing, essays, and/or reports? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Know how to do research on a topic? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Schedule your time well? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Organize your time and work demands? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Finish your work? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Do as well as you can? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Understand assignments that are asked of you? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Concentrate well? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Take notes easily? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Prefer to study alone? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Do as well as your friends do in school? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Distract easily? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Ask for help when you need it? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Study only the material that you like? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Feel anxious when taking a test? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |
| Have difficulty recalling studied material? | <input type="checkbox"/> Usually | <input type="checkbox"/> Never |

11. Rate the following TYPES OF TESTS as either easy or difficult for you to take:

- | | | |
|-------------------|-------------------------------|------------------------------------|
| Matching | <input type="checkbox"/> Easy | <input type="checkbox"/> Difficult |
| Multiple choice | <input type="checkbox"/> Easy | <input type="checkbox"/> Difficult |
| Fill in the blank | <input type="checkbox"/> Easy | <input type="checkbox"/> Difficult |
| Short answer | <input type="checkbox"/> Easy | <input type="checkbox"/> Difficult |
| Essay | <input type="checkbox"/> Easy | <input type="checkbox"/> Difficult |
| Problem solving | <input type="checkbox"/> Easy | <input type="checkbox"/> Difficult |

12. Thinking back over your years in school, have you had any trouble in the following areas?
(Check all that apply)

Reading:

- _____ Slow reading rate
- _____ Problems understanding what is read
- _____ Difficulty finding important points or main ideas
- _____ Confusion of similar words
- _____ Difficulty remembering what was read

Writing:

- _____ Frequent spelling errors
- _____ Letter reversals
- _____ Overly large handwriting
- _____ Slow writing rate
- _____ Difficulty with sentence structure or poor grammar
- _____ Difficulty copying from the board
- _____ Difficulty with spacing, capitals, or punctuation
- _____ Poorly formed or illegible letters
- _____ Compositions lacking organization and development of ideas

Math:

- _____ Problems with reasoning and abstract concepts
- _____ Difficulty recalling arithmetic operations
- _____ Problems remembering math facts
- _____ Confusion or reversal of numbers, number sequences, or math symbols
- _____ Difficulty reading or understanding word problems
- _____ Difficulty copying problems and keeping columns of numbers in line

Spoken Language:

- _____ Poor ability to remember or understand spoken instructions
- _____ Difficulty expressing ideas or thoughts aloud
- _____ Problems describing events or stories in proper sequence
- _____ Greater problems with grammar or ideas when speaking than when writing

Social Skills:

- _____ Difficulty “reading” other people, understanding body language, and facial expression
- _____ Problems interpreting or understanding subtle messages such as sarcasm, teasing, banter, or jokes
- _____ Confusion relating to time, directions, or visual-motor coordination
- _____ Inability to perform well at sports or games
- _____ Poor judgment leading to behavioral problems
- _____ Feeling of rejection due to learning problems
- _____ Talking out of turn or too loudly

**STUDENT ACKNOWLEDGEMENT OF RESPONSIBILITY AND
INFORMATION RELEASE AGREEMENT**

STUDENT NAME: _____

INSTITUTION: _____

By signing this agreement I am applying for diagnostic evaluation services from a New Jersey Special Needs Regional Center. I understand that if I am given an appointment for testing and fail to appear for the testing or cancel my appointment 24 hours in advance if I cannot keep the appointment, I will forfeit the fee that I have paid for the evaluation.

I am also giving permission to the Regional Center to:

- share information among the staff members of the Regional Center;
- share information with the referring Disability Service Provider at my institution;
- acquire additional background information from other professionals, if needed; and
- list my name on the Regional Center database for administrative purposes only.

Date

Student Signature

SERVICE PROVIDER REFERRAL FORM

Diagnostic Evaluation Packet submitted to Cumberland County College New Jersey City University
 Fairleigh Dickinson University Ocean County College
 Middlesex County College

Student eligibility confirmation: Student is enrolled in collegiate study leading to a degree/certificate
 Student is an undergraduate

STUDENT NAME: _____	SERVICE PROVIDER: _____
SOC. SEC. #: _____	INSTITUTION: _____
ADDRESS: _____	ADDRESS: _____
PHONE: _____	PHONE: _____
DATE OF BIRTH: _____	APPLICATION DATE: _____

1. Reason for referral: to determine if a learning disability is present
 to update a psychoeducational status

2. Previous testing:

Test type: _____	Date: _____
Test type: _____	Date: _____
Test type: _____	Date: _____

3. What concerns has the student shared with you about his/her learning problems at the college?

4. What kinds of disabilities do you suspect may be affecting the student's successful academic performance? *(Check all that apply)*

<input type="checkbox"/> Learning disability	<input type="checkbox"/> Emotional disability
<input type="checkbox"/> Mobility	<input type="checkbox"/> Hearing impairment
<input type="checkbox"/> Head injury	<input type="checkbox"/> Vision impairment
<input type="checkbox"/> Attention deficit disorder	<input type="checkbox"/> Health impairment

5. Additional comments:

Signature of Disability Service Provider

Location of Training Session

Date of Training Session

SCREENING INTERVIEW FORM

STUDENT NAME: _____ DATE: _____

SERVICE PROVIDER: _____

INSTITUTION: _____

1. How did you find our about our office? What seems to be the problem?

2. What are your reasons for coming to college?

3. Explain your past schooling and any type of assistance or support you received.

4. Explain what you think your learning difficulties may be. Discuss learning strengths and weaknesses.

5. Discuss your health history. Have there been any major health concerns in your life? Are you taking any medications?

6. Are there any pertinent family concerns?

7. Discuss your job history?

8. What are some changes you think you would like to make in your life? (e.g., academic, personal, vocational)

Observations by the interviewer:

Refer for diagnostic evaluation? Yes No