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| --- | --- | --- | --- | --- |
| **Child’s Name:** | | | | **Child’s Date of Birth:** |
| **Service Coordinator Name:** | | **Resident School District:** | | |
| **Check Domain(s) / subdomain(s) of concern:**    🞏 Personal-Social 🞏 Motor 🞏 Cognitive  🞏Adult Interaction 🞏Gross Motor 🞏 Attention and Memory  🞏 Peer Interaction 🞏 Fine Motor 🞏 Reasoning and Academic Skills  🞏Self-Concept and Social Role 🞏 Perceptual Motor 🞏 Perception and Concepts    🞏 Communication 🞏 Adaptive  🞏 Expressive Communication 🞏Self-Care  🞏 Receptive Communication 🞏Personal Responsibility | | | | |
| **If evaluation standards and procedures did not adequately measure the child’s abilities, describe your concerns regarding the child’s *quality* of performance, atypical behavior, or developmental patterns and if these are affecting the child’s daily routines *(to be completed by school district evaluator(s))*.** | | | | |
| **Describe the clinical observations that indicate future development will likely be affected without intervention (to be completed by school evaluator(s)).** | | | | |
| **The following multidisciplinary evaluation team members agree to the above *Informed Clinical Opinion* decision:** | | | | |
| **Name (print)** | **Title/Discipline** | | **Signature** | |
|  | **School District Rep.** | |  | |
|  | **School District Evaluator** | |  | |
|  | **School District Evaluator** | |  | |
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