**DCBS Number:**

**DCBS Name:**

**COMMONWEALTH OF KENTUCKY**

**CABINET FOR HEALTH AND FAMILY SERVICES**

**DEPARTMENT FOR COMMUNITY BASED SERVICES**

**EDUCATIONAL ASSESSMENT REFERRAL FORM**

Date of Referral:

Child’s Name:       DOB:

Address:

Phone:       Age:       Grade:

School:       Teacher:

Referring Person:       Title:

Phone:

1. Please describe the specific reasons you are referring this child.
2. Describe the methods you have tried to solve the problem(s).
3. What do you see as this child’s strengths and weaknesses in the academic and behavioral areas (reading skills, math skills, etc.)?
4. Please list all scores and the date given from the child’s most recent achievement test. Also, list any additional information from school records that would be helpful (IQ test, health information, attendance record, grade(s) repeated, etc.).