Revised September, 2016

Diagnostic Center, Central California
REFERRAL APPLICATION – PART I: DISTRICT INFORMATION

To District Staff Completing the Application:

It is very important that the items included in the checklist below be included in the application packet. The Application Review Committee meets weekly to review incoming referrals. If any portion of the packet is incomplete, it will result in a delay of the assessment. Also, we have found that most applications that are received after March 15, are scheduled for the following year.

Please work with the student's parents to ensure the diagnostic questions are the result of a collaborative effort to address the specific and prioritized concerns of the entire IEP team. At times, we find parents are unaware of the questions that have been submitted for the assessment.

It is important that you provide the parent with five (5) copies of the HIPPA release form. If the parent will release copies of reports to us directly, this also expedites the assessment scheduling process.

In order to expedite the assessment process, please enclose copies of any reports (including medical) that you may have on file. If you have any questions or concerns about completing the application packet, please call us for technical assistance (559) 243-4047.

Please check all items listed to ensure a complete referral application.

☐ 1. Referral Application - Part I: County/District/School Information
- ☐ All sections completed (**including Diagnostic Questions**)
- ☐ Signature of Authorizing Administrator **(required)**

☐ 2. Referral Application - Part II: Parent Information
- ☐ All Sections Completed
- ☐ Parent Signatures
- ☐ Signed authorization to disclose information
- ☐ Court rulings on custody agreements, educational rights, as appropriate

☐ 3. Complete Copy of Current IEP- If a new IEP will be developed before the assessment, send a copy of the updated IEP immediately after the IEP meeting.

☐ 4. Behavior Plan (as appropriate)

☐ 5. Most current Psychological Educational Report
- ☐ Initial ☐ Triennial ☐ Other Date:
- ***Most recent testing information which is older than 30 months will not be considered.***

☐ 6. Copies of any additional testing reports, including Functional Behavior Analysis

☐ 7. Health History Updates

☐ 8. Agency Reports (CCS, Regional Center, Mental Health, etc.), as applicable

☐ 9. Copy of Student's Weekly Schedule, including Designated Instructional Services

☐ 10. Recent Photograph of Student

☐ 11. Copy of any Mediation Agreement, as applicable

☐ 12. Academic Calendar to facilitate scheduling

CALIFORNIA DEPARTMENT OF EDUCATION

NOTE: Please type or print all information.

Diagnostic Center, Central California
1818 W Ashlan Ave, Fresno CA 93705
(559) 243-4047

Incomplete applications will be returned. Referrals will only be accepted from authorized special education administrators

REFERRAL APPLICATION – Part I

COUNTY/DISTRICT/SCHOOL INFORMATION

Diagnostic Center Use Only

Referral No:

REFERRING SCHOOL DISTRICT	*DATE OF APPLICATION*	*REFFERAL INITIATED BY:* ☐ *Parent* ☐ *LEA*

STUDENT INFORMATION

STUDENT NAME (Last, First, MI)			PARENT OR GUARDIAN'S NAME	
ADDRESS			PARENT CONTACT MOTHER HOME: WORK: CELL:	PHONE NUMBERS FATHER HOME: WORK: CELL:
CITY/STATE/ZIP CODE		COUNTY		
DATE OF BIRTH	ETHNICITY	GRADE		
GENDER ☐ Male ☐ Female	STUDENT IS: ☐ Fluent English Speaking (FES) ☐ Limited English Proficient (LEP) ☐ Non-English Speaking (NES) Primary Language		LANGUAGES SPOKEN IN THE HOME: INTERPRETER NEEDED FOR PARENT: ☐ YES ☐ NO	

PRIMARY DISABILITY

PLEASE ✓ APPROPRIATE BOX per IEP

☐	010	Intellectual Disability (ID)	☐	020	Hearing Impairment (HI)	☐	010 ID	☐	020 HI
☐	030	Deafness (DEAF)	☐	040	Sp/Lang. Impairment (SLI)	☐	030 DEAF	☐	040 SLI
☐	050	Visual Impairment (VI)	☐	060	Emotional Disturbance (ED)	☐	050 VI	☐	060 ED
☐	070	Orthopedic Impairment (OI)	☐	080	Other Health Impairment (OHI)	☐	070 OI	☐	080 OHI
☐	090	Specific Learning Disability (SLD)	☐	100	Deaf-Blindness (DB)	☐	090 SLD	☐	100 DB
☐	110	Multiple Disabilities (MD)	☐	120	Autism (AUT)	☐	120 AUT	☐	130 TBI
			☐	130	Traumatic Brain Injury (TBI)				

Multiple Disabilities Subcategories (Use only if 110 checked)

DISTRICT INFORMATION

CONTACT PERSON for this Referral (Mr., Ms., Mrs., Dr.)	NAME OF SCHOOL STUDENT ATTENDS	
TITLE	ADDRESS OF SCHOOL	
ADDRESS	CITY/STATE/ZIP CODE	COUNTY
CITY/STATE/ZIP CODE	PHONE	FAX
PHONE	TEACHER (Mr., Ms., Mrs., Dr.)	
E-MAIL	PRINCIPAL (Mr., Ms., Mrs., Dr.)	
STUDENT'S SCHOOL YEAR ☐ Traditional (SEPT-JUNE) ☐ Year Round--Dates off Track: ☐ Winter Break: ☐ Spring Break:	DAILY TIME AT SCHOOL: MINIMUM DAY: DAY OF WEEK: INSTRUCTIONAL TIME:	

LEA PROVIDING SPECIAL EDUCATION SERVICES	LEA OF RESIDENCE (If different from service LEA)	
NAME OF AUTHORIZING ADMINISTRATOR OF SPECIAL EDUCATION (Mr., Ms., Mrs., Dr.)		
AUTHORIZING SIGNATURE OF SPECIAL EDUCATION ADMINISTRATOR		
TITLE	PHONE	E-MAIL
ADDRESS	CITY/STATE/ZIP CODE	

REFERRAL QUESTIONS

Reason for Referral This section is of particular importance. Clearly state the reasons for the referral, as determined through collaborative efforts of education staff and parents/legal guardians.

DIAGNOSTIC QUESTIONS - Parent/District collaboration to identify specific, educationally-relevant questions: [Required regardless of reason for referral or who initiated request for referral.]
1.
2.
3.

EDUCATIONAL HISTORY

Date Student Qualified for Special Education Services:

Current Individualized Educational Program IEP Dated:

Program	Name of Teacher (Print full name)	Phone	E-Mail Address
General Education (full-inclusion)			
Resource Specialist Program			
Special Day Class Type:			
Psychologist			
Speech & Language			
Other DIS:			
Other DIS:			

List Previous Educational Placements

Class Placement	Inclusive Dates & Grades	School District

ASSESSMENT HISTORY (All Sections must be completed.)

PSYCHOLOGICAL

Include copies of reports for all tests administered within the past 30 months.

Is the student receiving counseling:

	Yes	No	If yes, inclusive dates:
Within the school program?	☐	☐	
With mental health agency?	☐	☐	Names(s) of Agency and/or Therapist:
With private individual?	☐	☐	

Has a functional behavior analysis been completed? Yes☐ No☐ **If yes, report must be included.**

Does the student have a behavior plan? Yes☐ No☐ **If yes, report must be included.**

Describe effectiveness of plan.

ACADEMIC

Include copies of reports for all tests administered within the past 30 months.

Is the student exempt from the State's assessment? Yes☐ No☐

Has the student been opted out of State assessment? Yes☐ No☐

If yes, describe what alternate assessment is in place to measure educational progress:

CAA Level:

Provide a brief description of current curricula/programs and methods of instruction used to teach skills in reading, math, and written language:

SPEECH/LANGUAGE

Include copies of reports for all tests administered within the past 30 months.

Describe materials and strategies used to address language delays/deficits.

MOTOR PROFICIENCY

Include copies of reports for all tests administered within the past 30 months.

Describe any concerns, interventions and/or accommodations

CURRENT FUNCTIONING

Student's strengths:

Student's interaction with adults:

Student's interaction with peers:

Student's overall behavior:

Does the student have a medical condition affecting educational progress? Yes☐ No☐

Please describe:

Is the student 16 years or older? If yes, attach Individual Transition Plan. Yes☐ No☐

If student is 16 years or older, has (s)he been involved in any work experience programs? Yes☐ No☐

Describe:

Is the student on track to receive a high school diploma? Yes☐ No☐

Please use a separate sheet to provide any additional information you would like to share.

Thank you!

THIS IS THE END OF THE DISTRICT REFERRAL APPLICATION SECTION. THE PARENT REFERRAL APPLICATION BEGINS ON THE FOLLOWING PAGE.

Revised September, 2016

Diagnostic Center, Central California
REFERRAL APPLICATION – PART II: PARENT INFORMATION

Si Ud. necesita asistencia para completar estas formas en inglés, contacte a su Director de Educación Especial en el distrito escolar de su hijo(a).

Parent Application Guideline:

The following checklist is provided to ensure your application is complete when submitted. It is very important that the items included on the checklist below be included in the application packet to avoid delays.

To expedite the assessment scheduling process, please **include copies of reports** completed by your student's physician or other providers. Releasing copies directly to us will allow us to review the file earlier.

If you have any questions or concerns about completing the application packet, please call us for technical assistance (559) 243-4047.

Please use this checklist to ensure a complete referral application.

☐ 1. **Referral Application – Part II: Parent Information**

- ☐ All Sections Completed
- ☐ Parent Signatures
- ☐ Signed AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

  Forms **for each** professional or agency involved with your child, in order to obtain the necessary records, unless you provide copies of the report(s) with this application.
- ☐ Court rulings on adoptions, custody agreements, educational rights, as appropriate

2. Agency Reports as applicable (*In order to expedite the processing of your application, please include copies of all reports you have*)**:**

- ☐ **Medical Reports**
  - ☐ All Physicians/Specialists
  - ☐ All Medical Tests
- ☐ **Psychological Reports**
  - ☐ Psychologist/Psychiatrist
  - ☐ LCSW and/or MFT
  - ☐ County Mental Health (CMH)
- ☐ **Agency Reports**
  - ☐ Regional Center
  - ☐ California Children's Services (CCS)
- ☐ **Other Professionals**
  - ☐ Optometrist/Ophthalmologist
  - ☐ Occupational Therapist/Physical Therapist
  - ☐ Speech Pathologist and/or Audiologist
- ☐ **Other:**

☐ **3. Recent Photograph of Student**

CALIFORNIA DEPARTMENT OF EDUCATION
Diagnostic Center, Central California
1818 W Ashlan Ave, Fresno CA 93705
(559) 243-4047

NOTE: Please type or print all information.

REFERRAL APPLICATION – Part II

Revised September, 2016

PARENT INFORMATION

Si Ud. necesita asistencia para completar estas formas en inglés, contacte a su Director de Educación Especial en el distrito escolar de su hijo(a).

INSTRUCTIONS: Your child is being referred to the Diagnostic Center for assessment services. This information form must be completed and returned to the School District to include in the application packet to the Diagnostic Center. To ensure confidentiality, you can request that this form remain in a sealed envelope in the application packet	DATE OF APPLICATION
APPLICATION COMPLETED BY (Your Name) / **RELATIONSHIP TO CHILD**	***DIAGNOSTIC CENTER USE ONLY*** ***REFERRAL NUMBER:***
STUDENT'S NAME (Last, First, MI)	AUTHORIZING SIGNATURE (Parent or Legal Guardian) I am authorizing this referral to the Diagnostic Center Central and give my permission for the following: 1) my son/daughter to be observed in his/her classroom; and/or 2) exchange of information between DCC staff and school district representatives. Print: Signature: _____
ADDRESS	
CITY/STATE/ZIP CODE	PRIMARY LANGUAGE OF STUDENT: School:
TELEPHONE NUMBER .	Home:
GENDER. ☐ Male ☐ Female / DATE OF BIRTH / IS CHILD ADOPTED* ☐ Yes ☐ No If yes, adoption date:	PARENT'S PRIMARY LANGUAGE

CHILD'S ETHNICITY (PLEASE ✓ APPROPRIATE BOX)

☐ Native American	☐ Korean	☐ Japanese	☐ Chinese	☐ Vietnamese	☐ Cambodian
☐ Laotian	☐ Asian Indian	☐ Other Asian	☐ Hawaiian	☐ Samoan	☐ Guamanian
☐ Tahitian	☐ African American	☐ White	☐ Filipino	☐ Hispanic	☐ Other Pacific Islander

MOTHER'S NAME (First, Last)	DATE OF BIRTH	**FATHER'S NAME** (First, Last)	DATE OF BIRTH
ADDRESS		ADDRESS	
CITY/STATE/ZIP	TELEPHONE: HOME PHONE:	CITY/STATE/ZIP	TELEPHONE: HOME PHONE:
EMPLOYED BY	CELLPHONE: WORK PHONE: EMAIL:	EMPLOYED BY	CELL PHONE: WORK PHONE: EMAIL:
OCCUPATION		OCCUPATION	
MOTHER IS ☐ Living with Family ☐ Divorced/separated * ☐ Deceased ☐ Other, please explain: *Attach copy of custody and/or adoption documents from Court		FATHER IS ☐ Living with Family ☐ Divorced/separated * ☐ Deceased ☐ Other, please explain: *Attach copy of custody documents from Court	
PLEASE DESCRIBE ANY LEARNING PROBLEMS MOTHER HAS: Last Grade Completed:		PLEASE DESCRIBE ANY LEARNING PROBLEMS FATHER HAS: Last Grade Completed:	
OTHER ADULT IN HOME RESPONSIBLE FOR CHILD: ☐ Step Parent		☐ Legal Guardian ☐ Other:	
NAME (First, Last)		DATE OF BIRTH	

ADDRESS	BUSINESS PHONE
CITY/STATE/ZIP CODE	OCCUPATION

Do you hold educational rights for your child? ☐ Yes ☐ No
(Please explain)

List other members of the household.

NAME	RELATIONSHIP TO STUDENT	DATE OF BIRTH

Describe your child's strengths and interests.

What concerns you most about your child?

What is the reason the school district is requesting a Diagnostic Center assessment?

What do you hope will be the outcome(s) of this assessment?

How are your child's interactions with peers? ☐ Poor ☐ Good ☐ Excellent

Describe any difficulties:

Has your child been suspended or expelled? ☐ Yes ☐ No

How are your child's interactions with adults? ☐ Poor ☐ Good ☐ Excellent

Describe any difficulties:

MEDICAL AND DEVELOPMENTAL HISTORY

Please answer the following questions as accurately as you can. If you do not understand a question, cannot remember, or wish to discuss the subject, put an (*) by the question and a team member will clarify this with you.

PREGNANCY AND BIRTH HISTORY

Natal and Perinatal History

Pregnancy: ☐ Planned ☐ Unplanned

Yes	No		COMMENTS
☐	☐	Abortions/miscarriages prior to this child?	
☐	☐	Any stillbirths or deaths before age one?	

Did you experience any of the following with this child:

Yes	No		Yes	No	
☐	☐	Emotional distress	☐	☐	Major Illness
☐	☐	Hemorrhage	☐	☐	Trauma
☐	☐	Infection	☐	☐	Medications (prescription/nonprescription)
☐	☐	Premature Delivery	☐	☐	Toxemia

Please explain comments marked “yes” above: _____

_____

Did any abnormalities occur at any time? (e.g., infections, dizziness, bleeding, high blood pressure?) ☐ Yes ☐ No

If yes, when, and describe problem and treatment: _____

_____

Did mother gain or lose weight during this pregnancy? ☐ gained ☐ lost Number of pounds:

Check any of the following that were applicable to mother during this pregnancy:

Yes	No		How Much? Daily	How Much? Weekly
☐	☐	Took vitamins		
☐	☐	Drank alcoholic beverages		
☐	☐	Smoked tobacco		
☐	☐	Took aspirin		
☐	☐	Drank Coffee		
☐	☐	On special diet		

Type of diet:

List any substance abuse (street drugs) before or during this pregnancy and time period this occurred.

_____

_____

Labor and Delivery

Was child full-term? ☐ Yes ☐ No Length of Gestation weeks

Birth weight lbs ozs.

Name of physician or who delivered this child:

Place of birth: (City and State) Name of Hospital:

PREGNANCY AND BIRTH HISTORY (continued)

Approximately, how long was labor? _____

Was labor: ☐ easy ☐ difficult ☐ complications

Please explain items marked "yes" above:

_____

Was there anything unusual about delivery? (forceps, breech, Cesarean) ☐ Yes ☐ No

_____

Was anesthesia used? ☐ Yes ☐ No Type: _____

Did child go home from the hospital with you? ☐ Yes ☐ No

Length of mother's hospital stay: _____ Length of child's hospital stay: _____

Did your child experience any of the following during the first year of life:

Yes	No		Yes	No	
☐	☐	Anoxia	☐	☐	Surgery
☐	☐	Exchange Transfusion	☐	☐	Excessive crying
☐	☐	Need for incubator or oxygen	☐	☐	Fetal distress
☐	☐	Jaundice	☐	☐	Need for detoxification
☐	☐	Poor feeding	☐	☐	Irritability
☐	☐	Re-hospitalization	☐	☐	Hypotonia (low tone, "floppy muscles")
☐	☐	Resuscitation	☐	☐	Hypertonia (increased tone)
☐	☐	Seizures	☐	☐	Other

Please provide details for all items checked above:

_____

_____

DEVELOPMENTAL HISTORY

Developmental Milestones

Sat unsupported at months; walked unsupported at months.

Babbled (e.g., used vowel/consonant-like sounds, sometimes singly or strung together) months ☐ Not observed

Used two or three words other than "mama" or "dada" at months (or years). ☐ Not observed

Spoke two or three-word sentences at years. ☐ Not observed

Toilet trained (bladder) at years months.

Toilet trained (bowel) at years months.

Bed wetting after age 5? ☐ Yes How long? ☐ No

Played with another child side-by-side; sometimes imitating the other's actions

☐ Yes Approximately what age? ☐ Not observed

Used toys/other objects in pretend play (e.g., pretended to drink from a play cup; talk on a play telephone; cook a meal; fix cars at a garage)? ☐ Yes Approximately what age? ☐ Not observed

Tricycle riding at 1 years Bicycle riding at 5 years

How old was your child when you first began to have a concern that perhaps (s)he was not developing the way you thought (s)he should? What area(s) of development seemed to be most problematic for your child?

_____

_____

_____

_____

Emotional/Behavioral Symptoms during the first 3 years of life (Please ✓ all that apply) :

☐	Babysitter difficulty	☐	Frequent crying
☐	Feeding difficulty	☐	Excessive fearfulness
☐	Head banging, rocking	☐	Discipline problems
☐	Tantrums	☐	Hyperactivity
☐	Colic	☐	Sleep disturbance

Other: _____

Which of these were of most concern to you? _____

Please add any other behavior that was a problem early on: _____

Note any problematic behaviors which continued after age 3 and for how long behaviors were observed.

_____

_____

CHILD'S MEDICAL HISTORY

Date of your child's last physical examination: _____

Does your child have a hearing loss? ☐ Yes ☐ No Wears aides? ☐ Yes ☐ No

Does you child wear glasses? ☐ Yes ☐ No If so, for how long? _____

Please bring his/her glasses or hearing aides to the assessment

Has your child ever experienced any of the following?

Yes	No	
☐	☐	Major illness
☐	☐	Major accidents/trauma
☐	☐	Heart condition or a heart murmur

Please comment further on any of the above, including the type of illness or accident, etc., and the <u>date</u>:

_____

_____

Yes	No	
☐	☐	Has your child begun any changes associated with puberty?
☐	☐	Has your child had any seizures? If so, when was the last episode? On average, how often does your child have a seizure? What was the date of the last EEG?
☐	☐	Has your child ever had a brain (head) Magnetic Resonance Image (MRI)? If so, date and reason:
☐	☐	Has your child ever had a brain (head) Computed Tomography (CT)? If so, date and reason:
☐	☐	Has your child ever had genetic testing? If so, date and reason:

What medical and/or clinical/psychiatric diagnoses are you aware of that have been given to your child?

_____

_____

List any **<u>previous</u>** medications your child has taken for seizures or behavioral problems:

Medication	Area Treated	Dosage	Dates Administered

List any **current** medications your child is on for seizures or behavioral problems:

Medication	Area Treated	Dosage	Time Administered

Please check (✓) any agencies that have assessed your child within the past year:

☐ Regional Center ☐ Mental Health Department ☐ Psychologist ☐ Neuropsychologist

FAMILY HISTORY

Please check any of the following illnesses or disabilities that have occurred in any of your family members (parents, grandparents, aunts, uncles, cousins, or brothers and sisters).

Yes	No		Relationship to child
☐	☐	Alcoholism	_____
☐	☐	Attention Deficit/Hyperactivity	_____
☐	☐	Autism	_____
☐	☐	Chromosomal Abnormality or Genetic Syndrome	_____
☐	☐	Drug Abuse	_____
☐	☐	Depression	_____
☐	☐	Anxiety	_____
☐	☐	Epilepsy	_____
☐	☐	Learning Disability	_____
☐	☐	Schizophrenia	_____
☐	☐	Bipolar Disorder	_____
☐	☐	Intellectual Disability (formerly Mental Retardation)	_____
☐	☐	Tic Disorder	_____
Other:		_____	_____

If you marked "yes" to any item above, please explain:

HOME LIVING AND LEISURE ACTIVITIES

Does your child generally perform self-care activities independently (dressing; bathing; brushing teeth, toileting)?

☐ Yes ☐ No Describe areas/skills that require frequent assistance by others:

Does your child generally follow regular routines at home (getting up in the morning, dressing, eating meals with other family members, doing homework at a certain time, going to bed at a set time)?

☐ Yes ☐ No Briefly describe circumstances:

Does your child perform any chore/household task on a regular basis (washing dishes, cleaning room, clearing table)?

☐ Yes What tasks/chores?

☐ No Briefly note reason (age, disability):

What discipline/management approaches are used to prevent/deal with behavior problems?

How does your child occupy him/herself at home during unscheduled or "free-choice" times?

Approximately how many hours of screen time does your child watch per week (e.g., TV, movies, videogames, iPad)?

Favorite TV shows, movies, video games:

Does your child use a home computer? ☐ Yes: For what purposes? ☐ No

Does your child have a friend(s) whom (s)he plays with on a regular basis outside of school hours? ☐ Yes ☐ No

What are favorite play activities?

EVALUATIONS AND SERVICES

In order for the Diagnostic Center to conduct a complete assessment, the assessment team needs access to records pertaining to both current and past evaluations and services provided to your child. Please list the physicians and/or agencies that are providing, or have provided, services to your child and complete an "Authorization for Use and/or Disclosure of Information Form" for each name listed below. This will reduce the wait time for requested information and facilitate the Center's review of the application.

In order to expedite the processing of your child's application, please include a copy of <u>all</u> the reports you have and provide a signed HIPAA for each provider and/or agency noted

CURRENT PHYSICIANS:

Name	Address	Phone	Dates
Pediatrician or Family Physician:			
Neurologist:			
Geneticist:			
Ophthalmologist:			

PHYSICIANS AND/OR CLINICS THAT HAVE PROVIDED TREATMENT IN THE PAST:

Name	Address	Phone	Dates
Pediatrician or Family Physician:			
Neurologist:			
Geneticist:			
Ophthalmologist:			
Neonatologist:			
Birth Hospital			

MEDICAL TESTS:

Name	Address	Phone	Dates
EEG:			
CTI/MRI Scans of Brain:			
Genetic Testing:			
Hospitalizations/Surgeries:			

MENTAL HEALTH SERVICES:

Name	Address	Phone	Dates
Psychiatrist:			
Psychologist:			
License Clinical Social Worker (LCSW) :			
Marriage Family Therapist (MFT):			
County Mental Health:			
Neuropsychologist:			

AGENCY REPORTS:

Name	Address	Phone	Dates
Regional Center:			
California Children's Services (CCS):			
Other:			

OTHER PROFESSIONALS OR AGENCIES THAT HAVE PROVIDED SERVICES:

Name	Address	Phone	Dates
Optometrist:			
Occupational Therapist:			
Physical Therapist:			
Audiologist:			
Speech Pathologist:			
Other:			

Thank you for your time and effort involved in completing this application.

CALIFORNIA DEPARTMENT OF EDUCATION
DIAGNOSTIC CENTER, CENTRAL CALIFORNIA

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Completion of this document authorizes the disclosure of individually identifiable health information as specified below in accordance with the Health Insurance Portability and Accountability Act (HIPAA}, which pertains to the Privacy and Security of Protected Health Information.

Instructions to Parents: One form must be completed for each doctor or agency that has provided services. Please include all completed authorization forms with your application.

I hereby authorize the disclosure of information of my child:

Child's Name: _____ Date of Birth: _____

Parent's/Guardian's Name(s):

Address: _____
Street City State Zip Phone

Individual and/or Organization disclosing information (e.g. Hospital, Doctor, Regional Center, Clinic):

Address: _____
Street City State Zip Phone

Organization authorized to receive this information:

DIAGNOSTIC CENTER, CENTRAL CALIFORNIA
1818 West Ashlan Ave • Fresno, CA 93705
(559) 243-4047 • Fax (559) 222-1673

Type of information to be disclosed:

- ☐ Medical
- ☐ Educational
- ☐ Regional Center/ CA Children's Services
- ☐ Occupational Therapy/ Physical Therapy
- ☐ Psychiatric/ Mental Health _____ Parent Signature Required
- ☐ Other Professional Services

Any and all information with regard to the above records may be released except: _____

The information requested will only be used for Assessment, Evaluation and Educational Planning

Duration This request shall become effective immediately and shall remain in effect for 12 months or until the completion of the Diagnostic Center evaluation.

Revocation I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Re-disclosure I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Diagnostic Center and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I understand I have a right to receive a copy of this authorization for my records. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

_____ _____
Signature of Parent/Legal Guardian or Child if 18 years or older Date

A copy of this authorization is as valid as an original.

To Doctor, Hospital or Clinic: To ensure completion of the Parent's application for assessment, it is essential that the information listed in this authorization be forwarded to the Diagnostic Center as soon as possible. Unfortunately, we cannot pay you for the report we are requesting, as there is no provision with the Department of Education, State of California, for expenditure of funds for this purpose.

CALIFORNIA DEPARTMENT OF EDUCATION

CALIFORNIA DEPARTMENT OF EDUCATION
DIAGNOSTIC CENTER, CENTRAL CALIFORNIA

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Child's Name: _____ Date of Birth: _____

Parent's/Guardian's Name(s):

Address: _____
Street City State Zip Phone

Individual and/or Organization disclosing information (e.g. Hospital, Doctor, Regional Center, Clinic):

Address: _____
Street City State Zip Phone

Organization authorized to receive this information:

DIAGNOSTIC CENTER, CENTRAL CALIFORNIA
1818 West Ashlan Ave • Fresno, CA 93705
(559) 243-4047 • Fax (559) 222-1673

Type of information to be disclosed:

- ☐ Medical
- ☐ Educational
- ☐ Regional Center/ CA Children's Services
- ☐ Occupational Therapy/ Physical Therapy
- ☐ Psychiatric/ Mental Health _____ Parent Signature Required
- ☐ Other Professional Services

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Signature of Parent/Legal Guardian or Child if 18 years or older Date

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DIAGNOSTIC CENTER, CENTRAL CALIFORNIA

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Instructions to Parents: One form must be completed for each doctor or agency that has provided services. Please include all completed authorization forms with your application.

I hereby authorize the disclosure of information of my child:

Child's Name: _____ Date of Birth: _____

Parent's/Guardian's Name(s):

Address: _____
Street City State Zip Phone

Individual and/or Organization disclosing information (e.g. Hospital, Doctor, Regional Center, Clinic):

Address: _____
Street City State Zip Phone

Organization authorized to receive this information:

DIAGNOSTIC CENTER, CENTRAL CALIFORNIA
1818 West Ashlan Ave • Fresno, CA 93705
(559) 243-4047 • Fax (559) 222-1673

Type of information to be disclosed:

- ☐ Medical
- ☐ Educational
- ☐ Regional Center/ CA Children's Services
- ☐ Occupational Therapy/ Physical Therapy
- ☐ Psychiatric/ Mental Health _____ Parent Signature Required
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