

**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 HIPAA 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

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: <input style="width: 80px; height: 20px;" type="text"/>

REFERRING SCHOOL DISTRICT	DATE OF APPLICATION	REFERRAL INITIATED BY: <input type="checkbox"/> Parent <input type="checkbox"/> LEA
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STUDENT INFORMATION					
STUDENT NAME (Last, First, MI)			PARENT OR GUARDIAN'S NAME		
ADDRESS			PARENT CONTACT		PHONE NUMBERS
CITY/STATE/ZIP CODE		COUNTY	MOTHER	FATHER	
DATE OF BIRTH		ETHNICITY	HOME:	HOME:	
GENDER		GRADE	WORK:	WORK:	
<input type="checkbox"/> Male <input type="checkbox"/> Female	STUDENT IS: <input type="checkbox"/> Fluent English Speaking (FES) <input type="checkbox"/> Limited English Proficient (LEP) <input type="checkbox"/> Non-English Speaking (NES) Primary Language		CELL:	CELL:	
			LANGUAGES SPOKEN IN THE HOME:		
			INTERPRETER NEEDED FOR PARENT: <input type="checkbox"/> YES <input type="checkbox"/> NO		

PRIMARY DISABILITY		PLEASE <input checked="" type="checkbox"/> APPROPRIATE BOX per IEP		Multiple Disabilities Subcategories (Use only if 110 checked)	
<input type="checkbox"/> 010 Intellectual Disability (ID)	<input type="checkbox"/> 020 Hearing Impairment (HI)	<input type="checkbox"/> 030 Deafness (DEAF)	<input type="checkbox"/> 040 Sp/Lang. Impairment (SLI)	<input type="checkbox"/> 010 ID	<input type="checkbox"/> 020 HI
<input type="checkbox"/> 050 Visual Impairment (VI)	<input type="checkbox"/> 060 Emotional Disturbance (ED)	<input type="checkbox"/> 070 Orthopedic Impairment (OI)	<input type="checkbox"/> 080 Other Health Impairment (OHI)	<input type="checkbox"/> 030 DEAF	<input type="checkbox"/> 040 SLI
<input type="checkbox"/> 090 Specific Learning Disability (SLD)	<input type="checkbox"/> 100 Deaf-Blindness (DB)	<input type="checkbox"/> 110 Multiple Disabilities (MD)	<input type="checkbox"/> 120 Autism (AUT)	<input type="checkbox"/> 050 VI	<input type="checkbox"/> 060 ED
		<input type="checkbox"/> 130 Traumatic Brain Injury (TBI)		<input type="checkbox"/> 070 OI	<input type="checkbox"/> 080 OHI
				<input type="checkbox"/> 090 SLD	<input type="checkbox"/> 100 DB
				<input type="checkbox"/> 120 AUT	<input type="checkbox"/> 130 TBI

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 <input type="checkbox"/> Traditional (SEPT-JUNE) <input type="checkbox"/> Year Round--Dates off Track: <input type="checkbox"/> Winter Break: <input type="checkbox"/> 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

<b>Reason for Referral</b>
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.

<b>DIAGNOSTIC QUESTIONS</b> - Parent/District collaboration to identify specific, educationally-relevant questions: <u>[Required]</u> 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:

- |                            |                              |                             |
|----------------------------|------------------------------|-----------------------------|
| Within the school program? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| With mental health agency? | <input type="checkbox"/>     | <input type="checkbox"/>    |
| With private individual?   | <input type="checkbox"/>     | <input type="checkbox"/>    |

If yes, inclusive dates:

Names(s) of Agency and/or Therapist:

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.

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**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:

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**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.

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# MOTOR PROFICIENCY

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

Describe any concerns, interventions and/or accommodations

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## CURRENT FUNCTIONING

Student's strengths:

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Student's interaction with adults:

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Student's interaction with peers:

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Student's overall behavior:

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

Please describe:

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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:

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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.

**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**

**REFERRAL APPLICATION – Part II**

**PARENT INFORMATION**

**Revised September, 2016**

*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.		
ADDRESS			Print: Signature: _____		
CITY/STATE/ZIP CODE			PRIMARY LANGUAGE OF STUDENT: School:		
TELEPHONE NUMBER			Home:		
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	IS CHILD ADOPTED* <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, adoption date:	PARENT'S PRIMARY LANGUAGE		
<b>CHILD'S ETHNICITY</b> (PLEASE ✓ APPROPRIATE BOX)					
<input type="checkbox"/> Native American	<input type="checkbox"/> Korean	<input type="checkbox"/> Japanese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Cambodian
<input type="checkbox"/> Laotian	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Guamanian
<input type="checkbox"/> Tahitian	<input type="checkbox"/> African American	<input type="checkbox"/> White	<input type="checkbox"/> Filipino	<input type="checkbox"/> Hispanic	<input type="checkbox"/> 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:		CITY/STATE/ZIP	TELEPHONE:	
	HOME PHONE:			HOME PHONE:	
EMPLOYED BY	CELLPHONE:		EMPLOYED BY	CELL PHONE:	
	WORK PHONE:			WORK PHONE:	
	EMAIL:			EMAIL:	
OCCUPATION			OCCUPATION		
MOTHER IS <input type="checkbox"/> Living with Family <input type="checkbox"/> Divorced/separated * <input type="checkbox"/> Deceased <input type="checkbox"/> Other, please explain: *Attach copy of custody and/or adoption documents from Court			FATHER IS <input type="checkbox"/> Living with Family <input type="checkbox"/> Divorced/separated * <input type="checkbox"/> Deceased <input type="checkbox"/> 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: <input type="checkbox"/> Step Parent			<input type="checkbox"/> Legal Guardian <input type="checkbox"/> 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  
  Abortions/miscarriages prior to this child?  
  Any stillbirths or deaths before age one?

COMMENTS
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Did you experience any of the following with this child:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Emotional distress	<input type="checkbox"/>	<input type="checkbox"/>	Major Illness
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Trauma
<input type="checkbox"/>	<input type="checkbox"/>	Infection	<input type="checkbox"/>	<input type="checkbox"/>	Medications (prescription/nonprescription)
<input type="checkbox"/>	<input type="checkbox"/>	Premature Delivery	<input type="checkbox"/>	<input type="checkbox"/>	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	Weekly	
<input type="checkbox"/>	<input type="checkbox"/>	Took vitamins	_____	_____	Type of diet:
<input type="checkbox"/>	<input type="checkbox"/>	Drank alcoholic beverages	_____	_____	
<input type="checkbox"/>	<input type="checkbox"/>	Smoked tobacco	_____	_____	
<input type="checkbox"/>	<input type="checkbox"/>	Took aspirin	_____	_____	
<input type="checkbox"/>	<input type="checkbox"/>	Drank Coffee	_____	_____	
<input type="checkbox"/>	<input type="checkbox"/>	On special 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	
<input type="checkbox"/>	<input type="checkbox"/>	Anoxia	<input type="checkbox"/>	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Exchange Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Excessive crying
<input type="checkbox"/>	<input type="checkbox"/>	Need for incubator or oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Fetal distress
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Need for detoxification
<input type="checkbox"/>	<input type="checkbox"/>	Poor feeding	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Re-hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Hypotonia (low tone, "floppy muscles")
<input type="checkbox"/>	<input type="checkbox"/>	Resuscitation	<input type="checkbox"/>	<input type="checkbox"/>	Hypertonia (increased tone)
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	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) :

- |  |  |
|--|--|
| <input type="checkbox"/> Babysitter difficulty | <input type="checkbox"/> Frequent crying       |
| <input type="checkbox"/> Feeding difficulty    | <input type="checkbox"/> Excessive fearfulness |
| <input type="checkbox"/> Head banging, rocking | <input type="checkbox"/> Discipline problems   |
| <input type="checkbox"/> Tantrums              | <input type="checkbox"/> Hyperactivity         |
| <input type="checkbox"/> Colic                 | <input type="checkbox"/> 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.

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### 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 your 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                       |                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Major illness                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Major accidents/trauma            |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart condition or a heart murmur |

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

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

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

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List any **previous** 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
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	_____
<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit/Hyperactivity	_____
<input type="checkbox"/>	<input type="checkbox"/>	Autism	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chromosomal Abnormality or Genetic Syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability	_____
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Intellectual Disability (formerly Mental Retardation)	_____
<input type="checkbox"/>	<input type="checkbox"/>	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?

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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 all 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:

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

**MENTAL HEALTH SERVICES:**

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

**AGENCY REPORTS:**

<b>Name</b>	<b>Address</b>	<b>Phone</b>	<b>Dates</b>
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.***











