



Greater Minnesota Psychological Assessments for Deaf, Hard of Hearing and Deafblind Students 2024-2025: Application Form

PLEASE NOTE: This is considered an “outside evaluation” and will require parent/guardian consent. Please confirm that the parent/guardian is interested in an evaluation by a psychologist outside the student’s school (a psychologist that is fluent in ASL with training/experience working with individuals with hearing loss) before submitting an application. Thank you!

Application date: _____ **Referred by:** _____
Relationship to student: Parent Teacher Other (specify): _____
Phone: _____ **Email:** _____

Student Information

Choose one level of service: Intellectual/Adaptive Only Evaluation OR Full Evaluation

Student Name: _____ **DOB:** _____ **Age:** _____
Gender: Male Female

Ethnicity:

American Indian
Asian American
Black/African American
Hispanic/Latino
White/Caucasian
Other:

County Assistance:

Minnesota Family Investment Program
County social worker
Other county assistance:
No county assistance

Student Address: _____ **City:** _____ **State:** _____ **Zip:** _____



Parent/Guardian Information

Parent/Guardian #1: Email: Phone:
Address (if different from student's): City: State: Zip:
Parent/Guardian #2: Email: Phone:
Address (if different from student's): City: State: Zip:

Evaluation Information

School district: **School name:**

3-year special education evaluation due date (month/day/year):

Reason(s) the evaluation is needed (Intellectual/Cognitive/IQ Testing):

(Check all that apply)

Attention	Emotional Functioning (anxiety, mood, emotional control)
Memory	
Learning	Behavioral Functioning
Adaptive/Self-Help/Independence Skills	Autism Evaluation
Social Functioning	Developmental Skills

Comment (optional):



Medical Conditions/Other Special Education Categories/Mental Health Conditions:

(Check all that apply)

- | | |
|-----------------------------------|---|
| None | Attention Deficit and Hyperactivity Disorder |
| Developmental Cognitive Delay | Mood Disorder (i.e. Depression, Bipolar Disorder) |
| Developmental Delay | Anxiety Disorder (General Anxiety Disorder, Social Anxiety) |
| DeafBlind | Seizure Disorder |
| Autism Spectrum Disorder | Other (specify): |
| Speech or Language Impairments | |
| Specific Learning Disabilities | |
| Emotional or Behavioral Disorders | |

Degree of Hearing Loss (Choose one):

- | | | | |
|------|----------|--------|----------|
| Mild | Moderate | Severe | Profound |
|------|----------|--------|----------|

Type of Hearing Loss (Choose one):

- | | | |
|---------------|------------|-------|
| Sensorineural | Conductive | Mixed |
|---------------|------------|-------|

Unilateral or Bilateral? (Choose one):

- | | | |
|-----------|---------------------|----------------------|
| Bilateral | Unilateral Left Ear | Unilateral Right Ear |
|-----------|---------------------|----------------------|

Has the student been diagnosed with Auditory Neuropathy Disorder? (Choose one):

- | | |
|-----|----|
| Yes | No |
|-----|----|

Does the student have vision loss?

- | | |
|-----|----|
| Yes | No |
|-----|----|

If the student has vision loss, explain:



Amplification (Check all that apply):

Bilateral Cochlear Implants

Unilateral Cochlear Implant-Right Ear

Bilateral Hearing Aids

Unilateral Cochlear Implant –Left Ear

Unilateral Hearing Aid – Right Ear

Unilateral Hearing Aid – Left Ear

FM system

Other (specify):

None

Comment (optional):

Communication Methods the Student Uses AT HOME (Check all that apply):

Spoken English

Other spoken language (specify):

American Sign Language

Tactile American Sign Language

Cued Language

Total Communication

Picture Communication System

Other (specify):

None

Comment (optional):

Communication Methods the Student Uses AT SCHOOL (Check all that apply)

Spoken English

Other spoken language (specify):

American Sign Language

Cued Language

Tactile American Sign Language

Total Communication

Picture Communication System

Other (specify):

Comment on school communication methods (optional):



Support Staff/Interpreters (*Check all that apply*):

- | | |
|--|------------------------------|
| Part time special education paraprofessional | Full Time ASL Interpreter |
| Full time special education paraprofessional | Cued Language Transliterator |
| DeafBlind Intervener | Other (specify): |
| Part Time ASL Interpreter | |

Comment (optional):

Student's Educational Placement (*Check all that apply*):

- | | |
|--|--|
| In Home Services | Pull out Special Education Services |
| Special Education Resource Room-more than 50% of the day | Push In Special Education Services |
| Special Education Resource Room-less than 50% of the day | Residential School for the Deaf or Blind |
| Mainstream | Other (specify): |

Comment (optional):