

**YOUR DISTRICT HERE**  
**Consent for Screening and Consultation**

Date of Request: \_\_\_\_\_ Referral made by: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_ School/Program: \_\_\_\_\_

Parents: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

This form constitutes a request for screening , with parent/guardian permission, to obtain information for the purpose of addressing indicated concerns within the student's general education environment. The information will be reviewed by the school's student assistance team and used to develop a plan for implementing appropriate pre-referral educational interventions.

**Type of Screening Request**

**Learning**  Academic  Working Memory/Executive Functioning  Cognitive

Other  
Specify:

**Social/Behavioral**  Health  Time on Task  Behavior/Personality  Social Skills

Other  
Specify:

**Speech-Language**  Expressive Language  Articulation/Speech  Listening/Comprehension  
 Grammar  Auditory Processing  Fluency or Voice

Other  
Specify:

**Occupational /Physical**  Fine Motor  Self-Care skills  Sensory  Gross Motor/Movement

Other  
Specify:

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 I **do** give consent to conduct the indicated screening(s)

I **do not** give consent to conduct indicated screening(s)

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**\*Copy to parent and forward to:**  District SLP  School Psychologist \_\_\_\_\_

TCSE OT/PT  Social Worker \_\_\_\_\_