CHEBOYGAN-OTSEGO-PRESQUE ISLE EDUCATIONAL SERVICE DISTRICT
Traumatic Brain Injury Worksheet/Multidisciplinary Evaluation Team Report

Name: _____ **MET Date:** _____
Address: _____ **Date of Birth:** _____
District / Building: _____ **Grade / Teacher:** _____
☐ **Parent input obtained by:** _____ **Date of Parent Contact:** _____

The following report is based on the data gathered in a comprehensive evaluation of the student by a multidisciplinary team, including parental input, relative to the eligibility criteria for services as a child with a Traumatic Brain Injury in Michigan (R340.1716). This is a recommendation to be considered by the IEP Team.

Members of the MET Team:

Parent	Special Education Teacher	Other
Parent	General Education Teacher	Other
Physician	Other	Other

FOLLOWING CRITERIA MUST BE MET:	**YES**	**NO**
1. An *acquired* injury to the brain which is caused by an *external* physical force, with medical documentation from physician. Diagnosis: _____ Physician Name _____ Date of Statement _____ The initial determination of eligibility requires an approved physician's signature or documentation and the statement is attached. A physician's signature or documentation is only required for a re-evaluation if determination of eligibility is questioned by the IEP Team during the REED/assessment planning.	☐ *	☐
2. ☐ As a result of the injury, there is a total or partial functional disability **OR** ☐ Psychosocial Impairment **OR** ☐ Both	☐ *	☐
3. This open or closed head injury results in an impairment in one or more of the following areas: ☐ Cognitive ☐ Language ☐ Memory ☐ Attention ☐ Reasoning ☐ Behavior ☐ Physical Functions ☐ Information Processing ☐ Speech	☐ *	☐
4. The term does not apply to brain injuries that are congenital or degenerative or to brain injuries induced by birth trauma.	☐ *	☐
5. This traumatic brain injury adversely affects educational performance, as documented by MET members.	☐ *	☐
6. Are physical adaptations required within the school environment? If so, these adaptations are as follows:	☐	☐

*** Must be "YES" in order to make a recommendation for eligibility as a student with a Traumatic Brain Injury.**

This is the recommendation to be made by the IEP Team:
☐ Determinant factor for eligibility is not lack of instruction in reading and math or limited English proficiency.
☐ Information was drawn from a variety of sources, including parent input.
☐ Attached report/s provide/s present level/s of performances and education needs of the student to enable the student to be involved in and progress in the general curriculum.
☐ Evaluation data **SUPPORTS** a recommendation of eligibility.
☐ Evaluation **DOES NOT SUPPORT** a recommendation for eligibility.
☐ Dissenting opinion attached.

Teacher Checklist for Physical Impairment / Other Health Impairment / Traumatic Brain Injury Multidisciplinary Team Report Supplement

Please complete this form prior to or in conjunction with a Physical Impairment / Other Health Impairment / Traumatic Brain Injury pre-referral or evaluation. The therapist(s) may assist you in completing this form or may review it with you when completed. The information which you provide on this form is an indication of the student's present level of performance.

Student's Name: _____ **D.O.B.:** _____ **Age:** _____ **Grade:** ____

Has student previously received Occupational Therapy? _____ Physical Therapy? _____
If so, where and when? _____

Is there a medically diagnosed physical or other health impairment? _____ If so, please name.

_____

Does this handicap adversely affect this student's educational performance? _____ If so, please be specific. _____

_____

_____

Is student currently receiving Special Education services? _____ If so, please list _____

_____

How would you rate this child's general educational performance in your class? Please check one:
_____ Above Average _____ Average _____ Below Average
Please explain: _____

Is any physical assistance or adaptation required for the above performance? If so, please describe

_____

_____

Does this child have any health or physical limitations? (include such things as medication or special equipment) _____

_____

Please briefly describe this child's overall physical performance in your class, including general mobility, fine motor coordination, self care ability, and classroom interaction. _____

_____

_____

_____

What methods have you tried in order to accommodate this child in your classroom, and how have they worked? _____

_____

_____

Form completed by: _____ School: _____ Date: _____
And to be presented with the completed PI, OHI, TBI MET Report, to the student's MET/IEPT Meeting.

Original: C.O.P. E.S.D. File **Copy:** Local School District Parent

OTHERWISE HEALTH IMPAIRED Eligibility • PHYSICALLY IMPAIRED Eligibility

TRAUMATIC BRAIN INJURY Eligibility

Physician's Referral

Student Name: _____ **Date:** July 1, _____

Student D.O.B.: _____ **Attending District:** _____

Parent(s) Name:	**Doctor:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**

Therapist: _____

With your approval, we would like to provide the following service/s to assist this student:

☐ Otherwise Health Impaired eligibility ☐ Physically Impaired eligibility ☐ Traumatic Brain Injury eligibility

The prescribed treatment is listed below:

_____

_____

_____

_____

This prescription will be in effect from: **July 1,** through **June 30,**

PHYSICIAN'S USE ONLY

Diagnosis: _____

Is this condition permanent? ☐ **Yes** ☐ **No**

☐ I agree with the treatment plan recommended above

☐ My recommended alternative therapy plan is as follows: _____

_____

_____

☐ Precautions: _____

_____

Physician's Signature: _____ **Date:** July 1, _____

(Note: Medicaid will not accept a **stamped** physician signature)

Please Print Physician's Name: _____

Send to: Cheboygan-Otsego-Presque Isle ESD
Special Education Department
6065 Learning Lane
Indian River MI 49749