WASHOE COUNTY SCHOOL DISTRICT
SPECIAL EDUCATION SERVICES
EVALUATION SUMMARY / PSYCHOEDUCATIONAL REPORT

DATE:

NAME: _____ **DOB:** _____ / _____ / _____ **AGE:** _____ **GRADE:** _____

SCHOOL: _____ **CASE MANAGER:** _____

TYPE OF REFERRAL: ☐ **INITIAL** ☐ **REEVALUATION** ☐ **OTHER:** _____

SCHOOL PSYCHOLOGIST: **PRIMARY LANGUAGE:**

REASON FOR REFERRAL:

Ia – COGNITIVE FUNCTIONING LEVELS

Ib – ACADEMIC FUNCTIONING LEVELS – SPECIFY TESTS GIVEN AND RESULTS

II – SOCIAL / EMOTIONAL / BEHAVIORAL

III – HEALTH AND DEVELOPMENTAL

WASHOE COUNTY SCHOOL DISTRICT
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DATE: _____

NAME: _____

IV – GROSS / FINE MOTOR – ADAPTIVE BEHAVIOR
OTHER (AS NEEDED; OT, APE, SLP, ETC.)
SUMMARY AND RECOMMENDATIONS