SOUTH BERGEN JOINTURE COMMISSION

Board of Education
500 Route 17 South, Suite 307
Hasbrouck Heights, NJ 07604
(T) 201-393-0475
(F) 201-288-2825
www.njsbjc.org

Christopher Hughes, PT, DPT, MS
Director of Special Projects, Outreach & Related Services
relatedservices@njsbjc.org

REQUEST FOR EVALUATION FORM:

OCCUPATIONAL, PHYSICAL, SPEECH THERAPY AND/OR OTHER RELATED SERVICES EVALUATION

Date of Request: ______	Grade: ______
Sending District: ______	Case Manager: ______
School Name: ______	Case Manager Phone: ______
School Phone: ______	Case Manager Email: ______
School Address: ______	Parent/Guardian: ______
Child's Name: ______	Parent/Guardian Phone: ______
Date of Birth: ______	Parent/Guardian Address: ______

Check Services Requesting: (Please give as much notice as possible)		**Initial Eval.**	**Re-Eval**
		(Please ✓ which type)	
Occupational Therapy Evaluation______	IEP Date_________	_____	_____
Physical Therapy Evaluation______	IEP Date_________	_____	_____
Speech Therapy Evaluation______	IEP Date_________	_____	_____
Behavioral Evaluation with (BIP*)______(extra hours)	IEP Date_________	_____	_____
Behavioral Evaluation without (BIP*)______	IEP Date_________	_____	_____
Educational Evaluation ______	IEP Date_________	_____	_____
Educational Evaluation requiring attendance at IEP Meeting**______	IEP Date _________	_____	_____
Psychological Evaluation______	IEP Date_________	_____	_____
Psychological Evaluation requiring attendance at IEP Meeting**______	IEP Date _________	_____	_____
Other Therapy Evaluation______ (Please specify therapy) ______________________________	IEP Date_________	_____	_____

* BIP Behavior Intervention Plan
** Attendance at IEP Meeting requires extra hours and will be billed.

____
Signature of Board Secretary or Designee

Updated 8/7/18