Developmental Pedatrics School/Program Questionnaire

Specialty Clinic Fax # 612-813-6953
Children's Hospital and Clinics – Minneapolis
Pediatric Specialty Clinics – CSC 390
2525 Chicago Avenue South
Minneapolis, MN 55404
For questions, please call: 612-813-6777

Child's Name: _____

This child has been referred for an evaluation in the Developmental Pediatric Clinic at Children's Hospitals and Clinics – Minneapolis. We are interested in gathering as much information as possible about this child in order to evaluate his/her developmental status and to make appropriate and useful recommendations. Information regarding your program and your observations about this child would be most appreciated. If several staff members see this child, please invite their input to this questionnaire.

Name of Program: _____

Name/Title of Person Completing Form: _____

Phone Number: _____ Fax Number: _____

Date Form Completed: _____

Date Child First Enrolled in Your Program: _____

Type of Program:		**Comments:**
Early Childhood Special Education Classroom		
Home Intervention Services		
Mainstream Preschool setting		
Daycare Center		
Family Daycare Program		
Other (please describe):		

Number of days/hours per week the child attends your program? _____
How regular has his/her attendance been? _____

Has the child been formally evaluated during this current school year? If so, please indicate when, the instruments used and the results. Please send copies of evaluations and IEP/IFSP if available. (Answer on back of questionnaire if necessary.)
Does this child receive special services within your program? If so, please indicate how often he/she is seen by the specialist?

Check all that apply:

	Individual	Group	Consultation	Direct Services	Monitoring	Frequency:
Occupational Therapy						
Physical Therapy						
Speech Therapy						
Psychology						
Social Work						
Other: _____						

What do you see as this child's strengths? _____
_____
_____

What do you see as this child's most concerning areas? Please describe briefly. (Answer on the back of this questionnaire if necessary.)

Attention Span: _____
_____
Behavior: _____
_____
Cognitive Development: _____
_____
Communication: _____
_____
Family Situation: _____
_____
Impulsivity: _____
_____
Motor Skills: _____
_____
Social Skills: _____
_____
Other: _____
_____

Do your concerns match the parents' concerns? _____
_____
_____

Please describe this child's interaction with other children and play skills?

How does this child relate to adults?

Do you have parent/family services available? If so, please describe.

Do parents utilize them?

What are your major goals for this child this year? (or attach IEP/IFSP)

Please describe the progress this child has made in your program?

Do you feel a program change or addition is warranted? Please describe.

What other information would you like us to have in regard to this assessment?

What information would you like from this assessment?

RETURN TO:
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