Licking County Educational Service Center Related Service Screening Form

Student:_____District/ School:_____

Date of Birth: _____ Teacher:_____Grade:_____

Date of Screening :_____

☐ Adaptive Physical Education ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech and Language Therapy ☐ Vision Services

Reason for Referral:

Screening Results:

RECOMMENDATION:

☐ **Formal Evaluation needed**

☐ **Rescreen at a later date_____**

☐ **Classroom recommendations provided to _____. See attached**

☐ **No educational relevant problem noted**

☐ **Other_____**

Therapist Signature_____ Date:_____

Email_____Phone_____