

Illinois Department of Human Services  
Bureau of Early Intervention

**EVALUATION/ASSESSMENT REPORT FORMAT**

Name:		EI #:	
Evaluation/Assessment Date:		Date of Birth:	
Age:		Adjusted Age:	
Evaluation/Assessment:	OT	PT	DT
			SLP
			SW
			Other

Evaluator:		Service Coord:		
Child is being observed in	__ home	__ daycare	__ clinic	__ other

A.) Diagnosis/Reason for Referral:

B.) Concerns expressed by parents in regard to their child' s development:

C.) Medical History/Reports (include social/emotional history when indicated):

D.) Behavioral Observation: (description of child during the assessment)

E.) Clinical Observation:

F.) Tests Conducted

(Not applicable to disciplines (i.e., nursing, social work, etc.) that evaluate/assess through clinical interview or clinical history rather than a standardized assessment tool.)

	Standardized Assessment Tool(s)		Score		Age Equivalent		Percent of Delay

G.) Clinical Narrative (should address typical/atypical development, specific areas of concern, functional skills & strengths, etc.)

H.) Further assessments recommended: (including assistive technology, family training, health consultation, diagnostic services, nursing, nutrition, psychological, and vision/hearing screening) (please state reason)

(For A through H use additional pages as necessary)

**RESULTS/IMPLICATIONS:**

Based on Part C EI criteria, this child may be eligible for Early Intervention Services in the State of Illinois due to: (please check one)

<input type="checkbox"/>	diagnosis of qualifying medical condition
<input type="checkbox"/>	30% or more delay in one or more area of development
<input type="checkbox"/>	At risk for developmental delay due to 3 or more qualifying risk factors as stated by DHS.
<input type="checkbox"/>	Further assessments/evaluations are needed in order to determine eligibility.
<input type="checkbox"/>	This child has not met the eligibility criteria for Early Intervention services in Illinois.

Recommendations for areas that intervention is needed: (please mark all that apply)

<input type="checkbox"/>	cognitive development
<input type="checkbox"/>	physical development, including vision and hearing
<input type="checkbox"/>	language, speech and communication development
<input type="checkbox"/>	social-emotional development
<input type="checkbox"/>	adaptive self-help skills development

RECOMMENDATIONS FOR GOALS, OUTCOMES, & STRATEGIES FOR SERVICES, WITH FREQUENCY, INTENSITY, AND DURATION WILL BE DETERMINED AT THE IFSP MEETING IN COLLABORATION WITH THE CHILD'S FAMILY BASED ON THEIR IDENTIFIED PRIORITIES.

Evaluator Signature	Date
Printed Name	Phone Number



Updated 6/03