East Carolina University Speech-Language and Hearing Clinic
Scottish Rite Foundation
Comprehensive Language and Literacy Evaluation

Department of Communication Sciences and Disorders
College of Allied Health Sciences
Greenville, NC 27834

Thank you for your interest in the Scottish Rite Foundation Comprehensive Language and Literacy Evaluation. Supported by funds from the North Carolina Scottish Rite Foundation, our clinic provides comprehensive diagnostic evaluations for children suspected of having disorders in oral language, reading, and/or written expression.

Enclosed in this packet you will find:

- Fact Sheet about our evaluations
- Submission Checklist
- Case History to be completed by a parent/caregiver
- School Questionnaire to be completed by teachers or school officials

In addition to this information, all children 8-years old and above are required to have a psychological evaluation, which includes an IQ score and any academic achievement scores that are available.

It is also helpful for us to have copies of any recent evaluation reports from therapists or other professionals, including information from school testing, current IEP, or IEP eligibility determination paperwork. A recent hearing evaluation (within three months) is helpful but not required. A hearing screening will be performed as needed as part of the diagnostic session.

Once your child's information is received, our clinicians will review and determine your child's eligibility. If approved, you will need to contact the clinic to schedule testing dates. Two dates are typically scheduled for this evaluation. There may be a waitlist, and clients are scheduled on first come, first serve basis.

While participation in Scottish Rite Foundation diagnostic evaluations do not require a physician's referral, it may be to your advantage to obtain one prior to your visit in case therapy is recommended following the evaluation. Scottish Rite funding only covers the cost of the evaluation.

A $50.00 fee is due on the initial day of the evaluation and covers both sessions. Please do not send any currency or personal checks when you return the enclosed forms. This is an administrative fee and is not reimbursable by insurance or Medicaid.

Please contact the clinic at (252) 744-6104 with any questions. We look forward to working with you and your child.

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FACT SHEET

What: The ECU Scottish Rite Foundation (SRF) Program specializes in providing low-cost diagnostic evaluations to children and adolescents who are suspected of having a language-based learning disability (i.e. difficulty with pre-reading skills, decoding and comprehension, written expression, understanding spoken language, and/or expressing themselves orally). Evaluations are designed and intended for children with limited access to resources (i.e. not already receiving tutoring, EC services in school, etc.). If the child attends public school, they are strongly encouraged to take advantage of the evaluation team available in the school setting. If concerns are not addressed with the school, we will consider providing a second opinion (additional screening documents may be required).

Who: Children from the ages of 6 to 18 are evaluated through the SRF program. Participants who are 8 and older should have a psychological evaluation (preferably within the last year) including individualized IQ scores. Children who have below average cognitive ability (80 or below) are not generally considered to be eligible for an evaluation through the SRF Program; however, they can receive an extensive oral language and/or reading and written language evaluation through the regular ECU Speech-Language and Hearing Clinic. Typical charges and fees will apply.

When: Parents or physicians may refer their child for an SRF evaluation. After the child has been referred to the clinic, an information packet will be sent to the child's parents/guardians, including a Case History Form and a School Questionnaire. These forms along with any previous evaluation results must be returned to the ECU Speech-Language and Hearing Clinic for review. When all information has been reviewed, the parents will receive a letter regarding their child's evaluation status and will need to schedule an appointment if approved. Since the evaluations are so thorough and comprehensive, two sessions are typically scheduled. A hearing screening will be performed as needed as part of the evaluation.

Where: The SRF program is housed in the ECU Department of Communication Sciences and Disorders and is located at the ECU Speech-Language and Hearing Clinic in the Allied Health Building, Greenville, NC.

SRF evaluations are completed by providers who are certified by the American Speech Language and Hearing Association (ASHA) and licensed by the State of NC as Speech-Language Pathologists. Graduate student clinicians also assist with the evaluations as part of their clinical education.

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Submission Checklist

- ☐ Case History Form completed
- ☐ Copies of reports from previous testing included
- ☐ Copies of documentation for current academic services and accommodations included (IEP, 504, etc.)
- ☐ School Questionnaire completed

Please list any other forms/documentation included:

_____
_____
_____
_____
_____
_____

Name of person submitting packet: _____

Relationship to child: _____

Signature: _____ **Date**: _____

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CASE HISTORY

Please fill out this form as COMPLETELY as possible.

Child's Name: _____
(Last) (First) (Middle) (Nickname)

Child's Date of Birth: _____ **Age**: _____ **Sex**: _____ **Race**: _____

Mother's Name: _____ **Father's Name:** _____

Mailing Address: _____
(Number & Street) (City) (State) (County) (Zip Code)

Phone Number: _____ **Email:** _____

School: _____ **Grade:** _____

Please indicate your concerns below (check all that apply):

- ☐ **Oral Reading**
- ☐ **Oral Reading Comprehension**
- ☐ **Silent Reading**
- ☐ **Silent Reading Comprehension**
- ☐ **Phonological Awareness** (rhyming, letter-sound correspondence, etc.)
- ☐ **Oral Language** (difficulty verbally communicating thoughts and ideas)
- ☐ **Written Language** (difficulty with grammar, formulating sentences, writing a story, etc.)
- ☐ **Executive Functioning** (attention, memory, following directions, etc.)
- ☐ **Spelling**
- ☐ **Speech Sound Production**
- ☐ **Speech Fluency**
- ☐ **Voice Concerns**
- ☐ **Social Skills / Interaction with Peers**
- ☐ **Other** (please list below)
  _____
  _____
  _____
  _____
  _____

What information are you hoping to gain from this evaluation?

_____

_____

_____

Please indicate previously completed testing (check all that apply):

☐ **Psychological** ☐ **Behavioral**

☐ **Academic** ☐ **Other** (please list below)

☐ **Speech-Language** _____

*Please include reports from previous testing.

Please indicate your child's current diagnoses (check all that apply):

☐ **ADD** (Date diagnosed: _____) ☐ **Mood Disorder** (Date diagnosed: _____)

☐ **ADHD** (Date Diagnosed: _____) ☐ **Genetic Syndrome** (Date diagnosed: _____)

☐ **Autism** (Date diagnosed: _____) ☐ **Other** (please list below)

☐ **Learning Disability** (Date diagnosed: _____) _____

☐ **Anxiety Disorder** (Date diagnosed: _____) _____

Please indicate which academic services your child currently receives (check all that apply):

☐ **IEP** ☐ **RTI** ☐ **Tutoring**

☐ **504 Plan** ☐ **MTSS** ☐ **Other** (please list below)

_____

_____

***Please include documentation of current services and accommodations.**

Please indicate how your child has been educated since COVID-19:

2019-2020: ☐ Remote ☐ In-person / Face-to-Face ☐ Hybrid ☐ Homeschool

2020-2021: ☐ Remote ☐ In-person / Face-to-Face ☐ Hybrid ☐ Homeschool

2021-2022: ☐ Remote ☐ In-person / Face-to-Face ☐ Hybrid ☐ Homeschool

***If your child is currently attending school, please ask the teacher(s) to complete the attached School Questionnaire.**

Name and address of person who referred you to this clinic:

_____

_____

Why has this appointment been requested?

_____

_____

FAMILY HISTORY

_____	_____	_____	_____	_____
(Mother's name)	(Age)	(Grades completed)	(Occupation)	(Phone #)
_____	_____	_____	_____	_____
(Father's name)	(Age)	(Grades completed)	(Occupation)	(Phone #)

If other than natural parents are guardians, please give name and relationship:

Name: _____ **Relationship**: _____

Names of Brothers and Sisters	**Age**	**Sex**	**Grade**	**Significant Diagnoses**
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____

Others living in home	**Relationship**
_____	_____
_____	_____

Have any other members of the family experienced difficulty with reading or language? (Please circle and describe)

Mother Father _____

*MGM *PGM _____

*MGF *PGF _____

Uncles Uncles _____

Aunts Aunts _____

Cousins Cousins _____

Brothers and Sisters _____

*MGM = Maternal Grandmother, MGF = Maternal Grandfather // PGM = Paternal Grandmother, PGF = Paternal Grandfather

BIRTH HISTORY

Pregnancy (months): _____ **Birth Weight**: _____

The following checklists help us determine whether there are early medical factors that might relate to your child.

Please place an **"X"** in the appropriate column.

Concerns Related to Birth	***True***	***Not True***	***Unknown***
Had bleeding during pregnancy			
Had to take medications during pregnancy			
Gained less than 15 pounds			
Took narcotic drugs or alcohol			
Had previous miscarriages			
Had previous premature babies			
Concerns Related to Birth	***True***	***Not True***	***Unknown***
Had an infection			
Labor lasted longer than 12 hours			
Labor lasted less than 2 hours			
Had a caesarean section			
Had difficult delivery			

Please describe any complications at birth not noted above: _____

_____

_____

_____

Concerns During First Months of Life	***True***	***Not True***	***Unknown***
Born with cord around neck			
Injured during birth			
Had trouble breathing			
Had exchange transfusion for jaundice			
Turned blue requiring oxygen			
Was a twin			
Had a serious infection			
Had difficulty feeding			

Concerns During First Months of Life	*True*	*Not True*	*Unknown*
Had skin problems	_____	_____	_____
Was very jittery	_____	_____	_____

Please describe any difficulties during your child's first year not noted above: _____

_____

_____

MEDICAL HISTORY

Health Concerns	*No*	*Yes (state ages and describe; also, who diagnosed?)*
Ear Infections	_____	_____
Meningitis	_____	_____
Seizures/Convulsions	_____	_____
High fevers (over 103)	_____	_____
Asthma	_____	_____
Trouble with Hearing	_____	_____
Trouble with Eyes	_____	_____
Headaches	_____	_____
Food Allergies	_____	_____
Other Allergies	_____	_____
Cleft lip/palate	_____	_____
Cerebral Palsy	_____	_____
ADD	_____	_____
ADHD	_____	_____

Please list and describe additional illnesses, injuries, and surgery not noted above:

_____

_____

_____

Names of current medications	*Dates*	*Frequency / Dosage*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Physician: _____ **Phone**: _____

Mailing Address: _____

Please list dates and results of most recent hearing and vision evaluations:

	Date	***Examiner***	***Results***
Vision	_____	_____	_____
Hearing	_____	_____	_____

DEVELOPMENTAL HISTORY

Please provide approximate ages for the following:

Sat alone: _____ **Toilet Trained: bladder** _____

Crawled: _____ **bowel** _____

Walked alone: _____ **night** _____

SPEECH AND LANGUAGE HISTORY

When did your child babble and coo? _____ **How often?** _____

When did your child begin using words? _____

What were your child's first five words? _____

How many words did your child have at 1 ½ years of age? _____

When did your child begin using two-word sentences? _____

Did your child begin to use speech, then slow down or stop talking? ☐ No ☐ Yes

If yes, please explain: _____

_____

Which does your child prefer to use now: ☐ Complete Sentences ☐ Phrases ☐ One or two words ☐ Sounds ☐ Gestures ☐ Other: _____

Does your child make sounds incorrectly? ☐ No ☐ Yes

If yes, which sounds? _____

Does your child hesitate, "get stuck", repeat, or stutter on sounds or words? ☐ No ☐ Yes

If yes, please describe: _____

How does your child's voice sound? ☐ Normal ☐ Hoarse ☐ Nasal ☐ Too high ☐ Too low ☐ Too loud ☐ Too soft ☐ Other: _____

If other than "normal," please explain: _____

_____

How well can your child's speech be understood by people outside the home? _____

Does your child have difficulty finding the appropriate word when talking? ☐ **No** ☐ **Yes**

If yes, please explain: _____

Can your child tell a story that contains several ideas? ☐ **No** ☐ **Yes**

How does your child's language ability compare to other children their age? _____

_____

Does your child struggle to remember information and/or directions? ☐ **No** ☐ **Yes**

Please list and describe additional speech-language concerns not noted above: _____

_____

_____

_____

BEHAVIORAL HISTORY

Please place an **"X"** in the appropriate column to describe your child.

BEHAVIORAL OBSERVATIONS	OFTEN	SOMETIMES	RARELY	NEVER	N/A
Has an even disposition / is easy to live with					
Usually seems happy					
Enjoys new experiences					
Takes pleasure in many activities					
Is friendly and outgoing					
Tolerates minor injuries without much compliant					
Shares or cooperates with others					
Accepts rules easily					
Is affectionate					
Is kind or sympathetic if someone else is hurt or sad					
Compromises easily					
Makes friends easily					
Takes turns well					
Finishes tasks independently					
Can delay reward or approval					

Please describe additional behaviors not noted above: _____

_____

EDUCATIONAL HISTORY

School: _____ **Grade**: _____

Mailing Address: _____ **Phone**: _____

Principal: _____ **Counselor**: _____

Teacher's Names	*Subjects*	*Current Grade*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child currently receive academic services in school? ☐ **No** ☐ **Yes**

If yes, please explain: _____

_____

Does your child currently receive speech-language therapy at school? ☐ **No** ☐ **Yes**

If yes, what goals are targeted and how often are services delivered? _____

_____

Does your child currently receive speech-language therapy privately? ☐ **No** ☐ **Yes**

If yes, what goals are targeted and how often are services delivered? _____

_____

Does your child currently receive tutoring at school? ☐ **No** ☐ **Yes**

If yes, what subjects are targeted and how often are services delivered? _____

_____

Does your child currently receive tutoring privately? ☐ **No** ☐ **Yes**

If yes, what subjects are targeted and how often are services delivered? _____

_____

Please describe any other services your child receives that are not noted above: _____

_____

_____

Did your child attend preschool? ☐ **No** ☐ **Yes**

If yes, at what ages and where? _____

Has your child repeated a grade? ☐ **No** ☐ **Yes → Grade**: _____

Has your child had frequent/extended absences? ☐ **No** ☐ **Yes**

If yes, please explain: _____

At what age/grade did you notice your child was having difficulty? _____

Please describe what you noticed that caused concern: _____

_____

_____

_____

Please describe your child's academic performance since kindergarten: _____

_____

_____

_____

_____

Please describe your child's current academic performance.

Strengths: _____

_____

Weaknesses: _____

_____

Please list current modifications and/or accommodations being made for your child in the classroom:

_____

_____

_____

Name of person completing this form: _____

Signature: _____

Relationship: _____ **Date**: _____

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School Questionnaire

Child: _____ **Current Grade**: _____

School: _____ **Principal**: _____

Address: _____ **Counselor**: _____
(Number and Street)

_____ **Psychologist**: _____
(City) (State) (Zip Code)

Phone #: _____ **Email**: _____

What year did child enroll in your school? _____ **Which grade(s) has child repeated?** _____

Vision Screening Date: _____ **Results**: _____

Hearing Screening Date: _____ **Results**: _____

Please list special services available in your school: _____

_____

_____

Teacher(s):	**Name**	**Subject**	**Grade**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Child's current services: (Resource, Speech-Language Therapy, Counseling, Tutoring, etc.)

Type / Subject	Hours per week / month
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list <u>all</u> achievement, speech/language, and psychological testing and <u>attach</u> copies:

Name of Test	Dates Administered
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Reading Programs: _____

Publisher: _____ **Level**: _____

Academic Performance

Please indicate child's typical performance in each area as compared to their peers.

Performance Area	Strong for Age	Appropriate for age	Delayed a year or more
Reading Comprehension			
Listening Comprehension			
Reading Rate			
Oral Reading			
Silent Reading			
Word Analysis Skills			
Sight Vocabulary			
Spelling			

Performance Area	Strong for Age	Appropriate for age	Delayed a year or more
General Knowledge			
Written Language			
Word Pronunciation			
Sound Differentiation			
Oral Sentence Structure			
Use of Vocabulary			
Writing from Dictation			
Copying Written Material			
Keeping Place in Reading			
Knowing Left from Right			
Discriminating Similar Words/Letters			
Following a Series of Directions			
Retaining Yesterday's Lessons			
Visual Memory			
Auditory Memory			
Performing Tasks in Correct Order			
Getting Letters in Correct Order			
Getting Words in Correct Order			

Behavioral Observations

Please indicate child's typical performance in each area as compared to their peers.

Behaviors	Less often than other children	As often as other children	More often than other children	Does Not Apply
Keeps getting out of seat				
Seems to do things without thinking				
Learns best on a one-to-one basis				
Is unaware of own mistakes				
Has trouble finishing a task				

Behaviors	Less often than other children	As often as other children	More often than other children	Does Not Apply
Seems to “tune-out” intermittently				
Is very impatient for rewards or approval				
Is easily distracted from work				
Hands and/or feet in motion				
Tires easily during a task				
Hurries through work				
Has marked variations in moods				
Stares for long periods				
Seems under-active or lethargic				
Is slow to understand a new task				
Makes careless mistakes				
Has trouble during unstructured time				
Fails to complete homework				
Disrupts classroom				
Often complains of pains or aches				
Frequently tardy or absent from school				
Has wet or soiled self at school				
Is not liked by other children				
Is solitary – does things alone				
Prefers to interact with younger children				
Bullies other children				
Often tells lies				
Frequently fights with other children				
Has stolen things				
Destroys own or others belongings				
Often worries about many things				
Cries easily				
Often appears unhappy or distressed				

Behaviors	Less often than other children	As often as other children	More often than other children	Does Not Apply
Is afraid of new situations				
Is quick to “fly off the handle”				
Is defiant toward teacher(s)				

Please list any academic or behavioral concerns/observations not listed above:

_____

_____

_____

_____

What specific information would you like to gain from this evaluation?

_____

_____

_____

_____

Additional comments:

_____

_____

_____

_____

Please ensure all questions have been answered and requested copies attached before submitting.

Teacher Signature: _____ **Date**: _____

Teacher Signature: _____ **Date**: _____

Counselor Signature: _____ **Date**: _____

Principal Signature: _____ **Date**: _____