



## SUCCESS IN MIND CONTACT FORM

Fax: **919.680.8949** Phone: **877.680.8921**

Mail to: **Center for Student Success, 324 Blackwell Street, Suite 1240, Durham, NC 27701**

Today's Date \_\_\_\_\_

Name of person completing form \_\_\_\_\_

Relationship to student \_\_\_\_\_

Student's full name \_\_\_\_\_

Nickname or name preference \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade in school \_\_\_\_\_

Male or Female (*please circle one*)

### Parent Information

Parent 1 Name \_\_\_\_\_

Relationship of parent 1 to student: (*circle one*) *biological, adoptive, step-parent, legal guardian*

Parent 2 Name \_\_\_\_\_

Relationship of parent 2 to student: (*circle one*) *biological, adoptive, step-parent, legal guardian*

Relationship of parents to each other: (*circle one*)  
*married, divorced, separated, domestic partners, single, widowed, other*

Address (street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_

Preferred daytime phone number ( ) \_\_\_\_\_ (*circle one*) *home, work, cell*

Home phone ( ) \_\_\_\_\_ Cell/Other ( ) \_\_\_\_\_

Preferred Contact Time \_\_\_\_\_ E-mail address \_\_\_\_\_

### School Information

School Level: (*circle one*) *elementary, middle, high*

School Type: (*circle one*)

*public, private/independent, Montessori, charter, home school, other* \_\_\_\_\_

School's name \_\_\_\_\_

School's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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## Referral Information

Referred by (name/relationship) \_\_\_\_\_

Please circle one: *physician, agency, school/teacher, friend, other* \_\_\_\_\_

How did you learn about the Student Success Program and/or All Kinds of Minds?  
\_\_\_\_\_  
\_\_\_\_\_

## Referral Concerns

We serve students who have the types of learning challenges experienced in general education classes. Below is a list of typical concerns that parents bring to Student Success Program. Because our assessments need to be focused, please select **up to 7 concerns** that are a priority for you and your child at the present time.

### Reading

- Reading decoding (i.e., sounding out or calling individual words)
- Reading comprehension (i.e., understanding text)

### Math

- Recalling math facts
- Remembering math procedures
- Understanding math

### Understanding

- Sophisticated thinking
- Comprehending when listening
- Understanding, in general
- Handling large amounts of information
- Handling input (e.g., maintaining focus, not getting distracted)

### Other

- Motivation about schoolwork
- Self-esteem about schoolwork
- Body coordination
- Getting along with others
- Remembering information in general
- Communicating orally
- Visual material (e.g., drawing, understanding graphs)
- Sequences, in general

### Writing

- Written expression
- Spelling
- Handwriting legibly and efficiently

### Working

- Having enough mental energy to work
- Regulating output (e.g., inhibiting impulses, planning work, catching mistakes)
- Using hands and fingers to perform tasks

- Working quickly enough, in general
- Managing time effectively
- Using strategies
- Getting work completed (even with good understanding)
- Keeping materials organized

Other concerns:

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## Estimates of Academic Skills

Please do your best to estimate your child's academic skill levels in the following areas:

Reading:       very delayed,    somewhat delayed,    on grade level,    somewhat advanced,    advanced

Math:             very delayed,    somewhat delayed,    on grade level,    somewhat advanced,    advanced

Writing:         very delayed,    somewhat delayed,    on grade level,    somewhat advanced,    advanced

\_\_\_\_\_ :       very delayed,    somewhat delayed,    on grade level,    somewhat advanced,    advanced

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Previous Assessment Findings

Has your child been assessed previously for school learning problems?    Yes    No

If yes, when was the most recent assessment completed? (*provide month and year*) \_\_\_\_\_

Where was the most recent assessment completed? (e.g., school system, clinic) \_\_\_\_\_

Who completed the most recent assessment? (e.g., psychologist) \_\_\_\_\_

If the most recent assessment included IQ testing, what was the Full Scale IQ? \_\_\_\_\_

If the most recent assessment resulted in a label or diagnosis, please select all that apply from the following list:

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Reading Disability    | <input type="checkbox"/> Speech Language Delay | <input type="checkbox"/> Autism     |
| <input type="checkbox"/> Writing Disability    | <input type="checkbox"/> Mental Retardation    | <input type="checkbox"/> Asperger's |
| <input type="checkbox"/> Math Disability       | <input type="checkbox"/> Developmental Delay   | <input type="checkbox"/> ADHD       |
| <input type="checkbox"/> Other Health Impaired |  |                                     |

Other labels/diagnoses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current Services and Supports

Does your child receive special educational services?  Yes  No

If yes, please mark all that apply:

pull-out resource:  none,  daily,  weekly,  less than weekly,  as needed basis

self-contained resource:  none,  daily,  weekly,  less than weekly,  as needed basis

pull-in/inclusive resource:  none,  daily,  weekly,  less than weekly,  as needed basis  
(in regular education classroom)

developmentally delayed:  none,  daily,  weekly,  less than weekly,  as needed basis  
classroom

speech-language therapy:  none,  daily,  weekly,  less than weekly,  as needed basis

occupational therapy:  none,  daily,  weekly,  less than weekly,  as needed basis

physical therapy:  none,  daily,  weekly,  less than weekly,  as needed basis

Other services at school: \_\_\_\_\_

Does your child receive services outside of school?  Yes  No

If yes, please mark all that apply:

individual tutoring:  none,  daily,  weekly,  less than weekly,  as needed basis

tutoring program (e.g., Sylvan):  none,  daily,  weekly,  less than weekly,  as needed basis

Other services outside of school: \_\_\_\_\_

### Emotional and/or Behavioral Issues

The Student Success Program focuses on academics, but does your child have any significant emotional or behavioral issues at home or at school?  Yes  No

If yes, please briefly describe your concerns about your child's emotional or behavioral difficulty, as well as how it is being addressed (e.g., counseling): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are these emotional or behavioral issues the primary reason you are seeking an assessment at the Student Success Program?  Yes  No

