CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
DEPARTMENT OF GRADUATE STUDIES
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

EDS 243
Assessment Practicum

Fall 2018 Course Reader

Meagan O'Malley, Ph.D.
Arlene Ortiz, Ph.D.
Stephen Brock, Ph.D.

TABLE OF CONTENTS

FALL SEMESTER 2018 SYLLABUS

Contacting Instructors:

Stephen Brock	Office Hours: Tuesdays 1pm – 4pm, or by appointment 225 Brighton Hall Phone: (916) 278-5919 Email: brock@csus.edu
Meagan O'Malley	Office Hours: Tuesdays 1 pm – 4 pm, or by appointment 225 Brighton Hall Phone: (916) 278-3459 Email: meagan.omalley@csus.edu
Arlene Ortiz	Office Hours: Wednesday 9:30 a.m.– 12:30 p.m., or by appointment 227 Brighton Hall Phone: (916**)** 278-5539 Email: arlene.ortiz@csus.edu

Course Objectives:

- To provide guided practice interviewing parents and other professionals for the purpose of obtaining information relevant to the assessment of a student with educational challenges.
    - Careful interviewing and review of any materials provided by the parent or school, and consultation with the instructor, provides the information necessary for the formulation of an assessment plan.

- To provide guided practice in the choice, administration, scoring, and interpretation of diagnostic tools such as the following: CBM probes, intelligence tests, achievement tests, social-emotional measures, neuropsychological tests, projective measures, behavior surveys and inventories, and adaptive behavior rating scales.

- To provide guided practice in the verbal and written communication of test results, diagnostic impressions and conclusions, and intervention strategies suggested by obtained assessment results.

NASP Practice Domains Addressed:

2.1: *Data-Based Decision Making and Accountability*
Practicum students will …
- acquire knowledge of varied methods of assessment and data collection for identifying strengths and needs of the clients they serve.
- demonstrate skills in the use of psychological and educational assessments, data collection strategies, and technology resources and apply data to design of their client's programs and services.

2.2: *Consultation and Collaboration*
Practicum students will …
- acquire knowledge of consultation skills important to working effectively with parents and teachers.
- demonstrate collaboration, consultation, and communication skills in their work with parents to communicate test results and develop intervention programs.

2.3: *Interventions and Instructional Support to Develop Academic Skills*
Practicum students will …

- acquire knowledge of evidenced based curriculum and instructional strategies.
- demonstrate the ability to use assessment data to support the development of their clients' cognitive and academic skills

2.4: *Interventions and Mental Health Services to Develop Social and Life Skills*
Practicum students will …

- acquire knowledge of evidenced based strategies to promote social-emotional functioning.
- demonstrate the ability to use assessment data to support the development of their clients' social-emotional functioning.

2.8: *Diversity in Development and Learning*
Practicum students will …

- acquire knowledge of individual differences, abilities, disabilities, and other diversity characteristics that are important to understanding the clients that they serve.
- demonstrate the ability to provide psychoeducational assessment services that are sensitive individual differences and diversity.

2.10: *Legal, Ethical, and Professional Practice*
Practicum students will …

- acquire knowledge of the history and foundation of their profession, of various service models, of relevant public policy development, and of ethical, professional and legal standards.
- demonstrate the ability to provide ethical, legal, and professional services to the clients they serve.

Program Objectives/ Students Outcomes:

- Students will utilize a wide range of methods in assessing client needs, designing appropriate interventions and using data-based decision making to evaluate the effectiveness of interventions.

Course Expectations:

- Prompt and regular attendance and active participation in discussions.
- Adherence to clinic policies and procedures.
- Completion of three diagnostic assessments, including submission of planning forms, testing, and psychoeducational reports.
- Reports will be written on all clients assessed.

1. Approved formats for diagnostic assessment reports are determined by your supervisor.
2. Unless otherwise noted on the attached Clinic/Assessment Schedule, complete reports ***must be submitted to your clinic supervisor at least one-week prior to the scheduled parent conference*** so that editing can be completed, the report scored for grading purposes, and a final report made available for parents/guardians at the parent conference. Complete reports MUST be available at the "Case Conference" as indicated on the schedule. Typically, the instructor makes a grade reduction when a complete report is not available at the Case Conference.
3. As long as a complete report is turned-in one week prior to the scheduled conference, changes may be made to the draft based upon the feedback given at case conferences.
4. Protocols must be double scored by a peer in your clinic section and submitted on time, according to supervisor specifications.
5. Student must follow all procedures outlined on the **Report Revision Process Checklist** and submit reports electronically unless prior arrangements are made with supervisor.

6. Separate from the report your supervisor may request a statement addressing Title 5's section 3030 special education eligibility requirements. This is to help students to begin to think in terms of whether or not they would recommend to an IEP team that persons similar to the client be considered eligible for special education and related services. Current regulations can be found in this reader as well as in the EDS 244 syllabus.
7. Utilize any unscheduled time (e.g., if a client cancels at the last minute) to observe other students, consult with the instructor, review test materials, score protocols, and plan for future sessions. Make a plan with your supervisor for using any unscheduled time.

Special Notes:

1. Assigned grades will be consistent with CSUS grading policy as described in the CSUS Catalog.
2. If you have a disability and require accommodations, you need to provide disability documentation to SSWD, Lassen Hall 1008, (916) 278-6955. Please discuss your accommodation needs with the instructor after class or during office hours early in the semester.
3. Basic Needs Support. If you are experiencing challenges in the area of food and/or stable housing, help is just a click, email or phone call away! Sacramento State offers basic needs support for students who are experiencing challenges in these areas. Please visit our Basic Needs website to learn more about your options and resources available. https://www.csus.edu/basicneeds/
4. Academic Honesty Policy: Go to http://www.csus.edu/admbus/umanual/UMA00150.htm for the CSUS Academic Honesty Policy and Procedures. Per University Policy all students are responsible for:
    a) Understanding the rules that preserve academic honesty and abiding by them at all times. This includes learning and following the particular rules associated with specific classes, exams, and course assignments. Ignorance of these rules is not a defense to a charge of academic dishonesty.
    b) Understanding what cheating and plagiarism are and taking steps to avoid them. Students are expected to do this whether working individually or as part of a group.
    c) Not taking credit for academic work that is not their own.
    d) Not knowingly encouraging or making possible cheating or plagiarism by others.

    Please refer to http://library.csus.edu/content2.asp?pageID=353 for a student tutorial on how to avoid plagiarism.

Procedures:

Adhering to the schedule is required. Clients are scheduled in advance and if an emergency necessitates any changes *you are responsible for first notifying your supervisor; and then notifying the clients, and then clinic staff*. The following list further specifies clinic procedures:

1. The office schedules all new clients for assessment and provides guidance on parking. Referrals are given to the practicum supervisor in the clinic "practicum file." The practicum supervisor reviews and distributes the referrals to students during practicum.
2. Students are expected to contact their client's parent/guardian prior to the assessment in order to …
    a. Confirm the appointment
    b. Clarify the referral question(s)
    c. Gather relevant history (e.g., developmental, educational, medical, social-emotional, and family)
3. If the client cancels completely before starting any assessment, the office schedules a new client and notifies the student. If the client tells the student directly they are cancelling their appointment, the student needs to tell the clinic staff immediately so that a new client can be scheduled.

4. If the client cancels either 1st or 2nd testing session and needs to reschedule during another practicum, the student reschedules with the family (with regular supervisor approval) and obtains approval of the supervisor who is supervising the given clinic. The student notifies the office of the change.
5. If the parent requests a different parent conference time, the student handles rescheduling (with regular supervisor approval) and obtains approval of the receiving supervisor. The student notifies the office.

Diagnostic Assessment

1. Evaluations are completed over two testing sessions.
2. Prior to the initial testing session, you will have contacted the parent to confirm the appointment, clarified the referral question, and completed an intake interview.
3. On the first day, you will meet briefly with parents and begin evaluating the student. When meeting with the parent, students must discuss limits of confidentiality, as well as the role of the CCDS as a teaching clinic and the role of you and your supervisor. **You must clearly specify that you are a graduate student in training and that in-vivo supervision is occurring during the assessment session**.
4. You should have reviewed any materials the parent has sent in and discussed an evaluation plan with your supervisor prior to this session. You may be required to submit case planning forms by your supervisor.
5. You will continue your assessment on the second week.
6. The specific assessment procedures to be conducted will be dependent on the reason for referral. There may be cases in which you require academic information before testing any other areas, and there may also be cases in which you decide to begin your evaluation with a cognitive assessment.
7. There will be two case conferences for each client so you have the opportunity to discuss your case with your peers after each testing session. On the first case conference for each case, you **must** bring in a report draft with tables of the work you completed after the first testing day, including but not limited to reason for referral, background information, and cognitive test results. You must also bring with you double scored protocols for tests administered on the first day of testing.
8. One week before the parent conference you **must** bring a complete first draft report to the Case Conference meetings held at the Clinic and submit an electronic copy as appropriate (see attached schedule for conference dates). Report grades are based on the first draft submitted to the instructor (although you will be given a few hours (amount of time determined by the clinic supervisor) to make changes to your report based upon the feedback given to you at the Case Conference meetings.
9. A second (and possibly third) draft should be submitted on the date requested by the instructor.
10. Your appointment with parents for reporting results should be scheduled as indicated on the attached schedule. Clinic staff will schedule feedback with parents but you are responsible for confirming the appointment with parents.
11. Bring two hard copies of your final report draft on the day of your parent conference and give them to your supervisor to sign and then stamp "confidential" before giving reports to parents. Make sure you format report as instructed by your supervisor.

Steps in Referral/Assessment Process

1. Referral is received with referral slip.
    a. Supervisor assigns a referral.
    b. Check to make sure information is complete.
    c. Check to make sure date is consistent.
    d. Identify reason for referral.
2. Parent information is received via telephone interview.

a. Review parent information.
b. Contact parent to confirm appointment, clarify reason for referral, and complete initial intake interview.
c. Double check accuracy of client's birth date.
d. Collect health & developmental information that is case-relevant. The clinic's developmental questionnaire may not ask questions that are particularly important for your case, so you will often need to follow-up with additional questions based on the case presentation. The BASC-3 Structured Developmental History form is a great resource to guide your questions.
e. Identify motor, cultural, and language issues that may affect choice of testing batteries.
f. Provide information of preparing child for testing (e.g., sleep, eating, glasses/hearing aids, taking medications as prescribed, proper attire, snacks)
g. Determine whether prior testing has been completed, including year and tests administered to avoid practice effects. Remind parents to bring copies of relevant materials (e.g., copies of report cards, standardized tests, prior evaluations).

3. Confer with the instructor to develop an assessment plan
    a. The *Test Day Planning* form in the course materials binder is designed to facilitate such consultation.
    b. The conference with the instructor to develop the assessment plan occurs as follows:
        i. Initial discussion of the referral question and the assessment plan is developed when referrals are initially assigned to the student in class.
        ii. Confirmation of, or consultation regarding, changes in the assessment plan occur in person with the instructor, via phone consult, or via email consult subsequent to completion of the phone call in which the appointment is confirmed, the referral question is clarified, and the intake interview is conducted with the parent.
4. Determine the tests you need and check to make sure they are available.
5. Call and remind parent of appointment one to two days before the assessment or conference.
6. Session-one:
    a. Parent interview
        i. Parent interview should be no more than 10 minutes. For confidentiality, make sure test room doors are closed when talking to parents. There should not be any client-related discussions in the hallways or waiting room.
        ii. Discuss limits of confidentiality.
        iii. Discuss role of the CCDS as a teaching clinic and the role of you and your supervisor. Specify that you are a graduate student in training and that in-vivo supervision is occurring during the assessment session.
        iv. Review any remaining parent questions and confirm student's birthdate.
        v. Ask parent about available snacks.
        vi. Set up final conference date and time (typically 3 weeks hence beginning 45-minutes before the end of the clinic session).
        vii. If appropriate, provide parents with rating forms to complete while they wait
    b. Assessment
        i. Follow your pre-approved assessment plan. If modifications seem warranted, consult with your supervisor prior to making any changes.
7. Session-two:
    a. Assessment.
        i. Follow your pre-approved assessment plan.
    b. Remind parent of conference date and time.
8. After the assessment and parent conference has been completed.
    a. Return completed folders to the Clinic Office.

i. Protocols are completely filled out and included.
ii. Final report is included.

b. Ensure that parents have received a copy of the report if for some reason it was not given to them at the parent conference.
c. Place all other testing materials with material to be shredded.
d. Erase any files that contain client identifiers from your computer.
e. Remove client names from any reports you are placing in your portfolio.
f. Thoroughly look through all materials at home, in folders etc. for diagnostic center items and return to center.

Test Administration and Scoring

If you have any questions regarding test administration and/or scoring, check with your supervisor, another instructor, or another student.

Some common errors include the following:

1. Incorrect calculation of Age at Testing. Make sure you verify, even when using app-based calculators.
2. Inappropriate prompts. Use prompts specified in the test manual.
3. Knowing when and when not to prompt.
4. Pace when delivering oral stimuli such as digits.
5. Difficulties with stop watch.
6. Failure to record timed items.
7. Incorrect starting points.
8. Failure to establish basal and ceiling rules as outlined in the test manual.
9. Not writing down responses verbatim.
10. Incorrect subtest instructions.
11. Over extensive probes.
12. Lack of behavior observations noted on protocol.
13. Not taking time to establish rapport.
14. Inappropriate interpretation of test scores.

Test Check-Out Procedures:

1. CCDS Test check out procedures

i. Students **MUST** sign-out any test that they wish to take out of the Clinic. This is to be done by making use of the sign-out/sign-in sheet located in the clinic office. Tests may only be checked out subject to other classes in the clinic and will be done on a rotating basis by clinic section. Tests may be available during the following times:

a. After 4:00 PM on Tuesdays and all day Wednesday.
b. **After 4:00 PM on Thursdays, and all day Friday, Saturday, Sunday, and Monday.**

ii. All tests **MUST** be signed-in by **5:00 PM every Monday**, and by **5:00 PM every Wednesday**. All tests need to be available for use in the Clinic all day on Tuesday and all day Thursday.
iii. **Never check out a test if it is the only copy** or the last copy of any test. There must always be one copy in the clinic of every test at all times.
iv. **Never take the last test protocol if it is the only copy**. Alert staff if protocols in any file folder are low.
v. Students who take a test out of the Clinic without first signing it out will lose the privilege of being able to checkout tests for the remainder of the semester.

vi. Students who consistently fail to sign-in tests at the designated time will also lose the privilege of being able to checkout tests.
vii. If Diagnostic Clinic supervisors and staff judge that there is a chronic failure to check tests out and to return them by the designated times, the privilege of being able to checkout tests will be discontinued for all students.

Clinic Etiquette:

Many students from different classes use the clinic. Therefore, it is important that we do whatever we can to be respectful of and courteous to each other. There is frequently a sense of urgency in the clinic as everyone feels a time crunch at one point or another. However, abiding by some simple rules and keeping a few important things in mind can help significantly.

- Making transitions from one group to another as easy as possible will be aided by remembering to:
  - Fold down tables and put them away
  - Return testing kits as directed
- Noise carries. Be as quiet as possible with conversations. Don't hesitate to remind anyone, we need to help each other.
- Respect confidentiality. Never forget that we are working with people who have feelings about themselves and their children**. Avoid discussion, even general conversation about client performance, in public areas (e.g., hallways, waiting room).**
- Food and drink are allowed in the clinic, but remember to clean up anything you bring in. It is a good idea to bring simple snacks and a bottle of water for the child you are testing. Be sure to ask the parent about offering food to avoid allergy-related issues or encourage parent to provide a snack/water.
- Dress appropriately. **Wear professional clothes** on days you are testing or meeting with parents. The cubicles are often very warm, so layers are advised.

Grading:

Grades are based on student competency in the following areas:

1. Interviewing strategies with client, parent, and other professionals.
2. Assessment planning based on the referral question.
3. Sound assessment practices.
4. Verbal communication of results.
5. Accurate scoring and statistical interpretation of test results.
6. Development of diagnostic impressions based on information from testing.
7. Formulation of interventions and recommendations.
8. Written communication of results.
9. Organization and completion of tasks in a timely manner.

Observation of assessment sessions, parent interviews and conferences, and case staffing meetings are used to document competencies 1 to 4, and will be graded using the Test Administration Evaluation and Parent Conference Evaluation forms found in your course reader. Competencies 5 to 9 are documented by completion of psycho-educational reports. First drafts of the 3 clinic-based assessments (due a minimum of one week before the scheduled parent conference) are graded using the Psycho-educational Evaluation Form found in your course reader.

Grade Distribution (in percent of total points available):

Your grades are based on total points earned across all three diagnostic cases. The total points available per case will vary by individual. For the CSUS School Psychology program, grades of less than a B- are considered not passing.

94-100: A
90-93: A-
84-89: B
80-83: B-
<80 not passing

Clinic Activity Times:
Morning Clinic (Typical Schedule)

8:00	Case briefing with supervisor Set up test room
8:15	Meet with parent, receive paperwork, ensure signed consent
8:30 – 11 a.m.	Begin testing with client ▪ You must have at least one break ▪ Confirm conference appointment with parent
11:15	Parent conference appointment on selected weeks: review results, provide written report
11:40	Break down testing cubicle. Leave no trace that you used the room. Case Debriefing

Afternoon Clinic (Typical Schedule)

1:00	Case briefing with supervisor Set up test room
1:15	Meet with parent, receive paperwork, ensure signed consent
1:30 – 4:00	Begin testing with client ▪ You must have at least one break ▪ Confirm conference appointment with parent
4:15	Parent conference appointment on selected weeks: review results, provide written report
4:40	Break down testing cubicle. Leave no trace that you used the room. Case Debriefing.

CLINIC SCHEDULE
TUESDAY FALL 2018 CLINIC SCHEDULE
8 AM – 11:50 AM | Brock

Note: Timelines provided in this schedule can be modified on a case-by-case basis with supervisor approval. If your case is rescheduled due to client cancellation or absence, your supervisor will work with you to develop a revised schedule; however, it is your responsibility to independently follow your revised schedule as the supervisor will not be providing you reminders. *Requests for extensions must be approved via email at least 24 hours prior to the deadline.*

Date	Activity	Assignments
August 28	Orientation	1. Review course reader, templates, and Canvas file structure 2. Review expectations for protocols and case files 3. Review clinic expectations and sign clinic confidentiality and procedures forms 4. Complete special instruction assigned reading for Sep 4 class
September 4	Special Instruction Topic Preview Diagnostic Assessment 1 (DX1)	1. Call DX1 family to introduce self, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 2. Consult with supervisor as needed regarding reason for referral and assessment protocol; 3. By 5 p.m. on Friday, Sep 7: a. Complete Case Plan for DX1/A and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
September 11	Diagnostic Assessment DX1/A	1. Score DX1/A protocols, obtain peer review of protocol scoring before populating tables. 2. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Sep 18. 3. Complete special instruction assigned reading for Sep 18 class
September 18	Case Conference DX1/A Special Instruction Topic	1. Provide DX1/A peer-reviewed protocols to supervisor for review and approval at start of class on Sep 18 2. By 5 p.m. on Friday, Sep 21: *a.* Based on results from Day 1, revise Case Plan and submit to supervisor. *Submit with populated Day 1 tables.*
September 25	Diagnostic Assessment DX1/B	1. Obtain peer review of Dx1 day 2 protocols before tabling and reporting.

October 2	Case Conference DX1/B Preview Diagnostic Assessment 2 (DX2)	DX1 1. Submit peer reviewed protocols from DX1/B to supervisor for review and approval on or before Oct 2. 2. Bring first complete draft of DX1 case report for in-class case conferencing. 3. Submit DX1 case report to supervisor for grading and feedback by 11:59 pm on Wednesday, Oct 3 4. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 5. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor. DX2 1. Call DX2 family to introduce yourself, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 2. Consult with supervisor as needed regarding reason for referral and assessment protocol (in-person, via email, or phone call); 3. By 5 p.m. on Friday, Oct 5: a. Complete Case Plan for DX2/A and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
October 9	Diagnostic Assessment DX2/A Parent conference DX1	DX1 1. Conduct DX1 parent conference following approved parent conference plan. 2. Bring 2 copies of DX1 report for parent conference DX2 1. Score DX2/A protocols, obtain peer review of protocol scoring before populating tables. 3. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Oct 16. 4. Complete special instruction assigned reading for Oct 16 class
October 16	Case Conference DX2/A Special Instruction Topic	1. Submit peer reviewed protocols from DX2/A to supervisor for review and approval on or before Oct 16. 2. By 5 p.m. on Friday, Oct 19: a. Based on results from Day 1, revise Case Plan and submit to supervisor. Submit with populated Day 1 tables.
October 23	Diagnostic Assessment DX2/B	1. Obtain peer review of DX2/B (day 2) protocols before tabling and reporting.

October 30	Case Conference DX2/B Preview Diagnostic Assessment 3	DX2 1. Submit peer reviewed protocols from DX2/B to supervisor for review and approval on or before Oct 30. 2. Submit first complete draft of DX2 case report for in-class case conferencing. 3. Submit DX2 case report to supervisor for grading and feedback by 11:59 pm on Wednesday, Oct 31 4. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 5. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor. DX3 1. Call DX3 family to introduce yourself, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 2. Consult with supervisor as needed regarding reason for referral and assessment protocol (in-person, via email, or phone call); 3. By 5 p.m. on Friday, Nov 2: a. Complete Case Plan for DX3 and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
November 6	Diagnostic Assessment DX3/A Parent conference DX2	DX2 & DX3/A 1. Score DX3/A protocols, obtain peer review of protocol scoring before populating tables. 2. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Nov 13. 3. Conduct DX2 parent conference following approved parent conference plan 4. Bring 2 copies of DX2 report for parent conference 5. Complete assigned reading for Nov 13 class
November 13	Case Conference DX3/A Special Instruction Topic	1. Submit peer reviewed protocols from DX3/A to supervisor for review and approval on or before Nov 13. 2. By 5 p.m. on Friday, Nov 16: a. Based on results from Day 1, revise Case Plan and submit to supervisor. Submit with populated Day 1 tables.
November 20	THANKSGIVING WEEK NO CLASS	THANKSGIVING WEEK NO CLASS You can have class this week and move everything up one week but families may be on vacation
November 27	Diagnostic Assessment DX3/B	1. Obtain peer review of Dx3 day 2 protocols before tabling and reporting.

December 4	Case Conference DX3/B	1. Submit peer reviewed protocols from DX3/B to supervisor for review and approval on or before Dec 4. 2. Submit first complete draft of DX3 case report for in-class case conferencing. 3. Submit DX3 case report to supervisor for grading and feedback by 11:59 pm on Wednesday, Dec 5. 4. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 5. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor.
December 11	Parent conference DX3	1. Conduct parent conference following approved feedback outline. Note: Parent conferences on this day may be scheduled to start at any time between 8:15-11:00 a.m. If you and your family agree on a new time for parent conference, please alert the clinic front office staff.

THURSDAY FALL 2018 CLINIC SCHEDULE
8 AM – 11:50 AM | Ortiz

Note: Timelines provided in this schedule can be modified on a case-by-case basis with supervisor approval. If your case is rescheduled due to client cancellation or absence, your supervisor will work with you to develop a revised schedule; however, it is your responsibility to independently follow your revised schedule as the supervisor will not be providing you reminders. *Requests for extensions must be approved via email at least 24 hours prior to the deadline.*

Date	Activity	Assignments
August 30	Orientation	5. Review course reader, templates, and Canvas file structure 6. Review expectations for protocols and case files 7. Review clinic expectations and sign clinic confidentiality and procedures forms 8. Complete special instruction assigned reading for Sep 6 class
September 6	Special Instruction Topic: Review & Practice Caregiver Interview Techniques for Psychoeducational Assessment Preview Diagnostic Assessment 1 (DX1)	4. Call DX1 family to introduce self, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 5. Consult with supervisor as needed regarding reason for referral and assessment protocol; 6. By 5 p.m. on Sunday, Sep 9: a. Complete Case Plan for DX1/A and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
September 13	Diagnostic Assessment DX1/A	4. Score DX1/A protocols, obtain peer review of protocol scoring before populating tables. 5. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Sep 20. 6. Complete special instruction assigned reading for Sep 20 class
September 20	Case Conference DX1/A Special Instruction Topic: Review Predicted Difference Discrepancy Analysis	3. Provide DX1/A peer-reviewed protocols to supervisor for review and approval at start of class on Sep 20 4. By 5 p.m. on Sunday, Sep 23: *a.* Based on results from Day 1, revise Case Plan and submit to supervisor. *Submit with populated Day 1 tables.*
September 27	Diagnostic Assessment DX1/B	2. Obtain peer review of Dx1 day 2 protocols before tabling and reporting.

October 4	Case Conference DX1/B Preview Diagnostic Assessment 2 (DX2)	DX1 6. Submit peer reviewed protocols from DX1/B to supervisor for review and approval on or before Oct 4. 7. Bring first complete draft of DX1 case report for in-class case conferencing. 8. Submit DX1 case report to supervisor for grading and feedback by 11:59 pm on Friday, Oct 5 9. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 10. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor. DX2 4. Call DX2 family to introduce yourself, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 5. Consult with supervisor as needed regarding reason for referral and assessment protocol (in-person, via email, or phone call); 6. By 5 p.m. on Sunday, Oct 7: a. Complete Case Plan for DX2/A and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
October 11	Diagnostic Assessment DX2/A Parent conference DX1	DX1 5. Conduct DX1 parent conference following approved parent conference plan. 6. Bring 2 copies of DX1 report for parent conference DX2 2. Score DX2/A protocols, obtain peer review of protocol scoring before populating tables. 7. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Oct 18. 8. Complete special instruction assigned reading for Oct 18 class
October 18	Case Conference DX2/A Special Instruction Topic: Guidelines for providing effective feedback & recommendations	3. Submit peer reviewed protocols from DX2/A to supervisor for review and approval on or before Oct 18. 4. By 5 p.m. on Sunday, Oct 21: a. Based on results from Day 1, revise Case Plan and submit to supervisor. Submit with populated Day 1 tables.
October 25	Diagnostic Assessment DX2/B	2. Obtain peer review of DX2/B (day 2) protocols before tabling and reporting.

November 1	Case Conference DX2/B Preview Diagnostic Assessment 3	DX2 6. Submit peer reviewed protocols from DX2/B to supervisor for review and approval on or before Nov 1. 7. Submit first complete draft of DX2 case report for in-class case conferencing. 8. Submit DX2 case report to supervisor for grading and feedback by 11:59 pm on Friday, Nov 2 9. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 10. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor. DX3 4. Call DX3 family to introduce yourself, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 5. Consult with supervisor as needed regarding reason for referral and assessment protocol (in-person, via email, or phone call); 6. By 5 p.m. on Sunday, Nov 4: a. Complete Case Plan for DX3 and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
November 8	Diagnostic Assessment DX3/A Parent conference DX2	DX2 & DX3/A 6. Score DX3/A protocols, obtain peer review of protocol scoring before populating tables. 7. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Nov 15. 8. Conduct DX2 parent conference following approved parent conference plan 9. Bring 2 copies of DX2 report for parent conference 10. Complete special instruction assigned reading for Nov 15 class
November 15	Case Conference DX3/A Special Instruction Topic: Review and Practice Behavioral Strategies for Psychoeducational Assessment	3. Submit peer reviewed protocols from DX3/A to supervisor for review and approval on or before Nov 15. 4. By 5 p.m. on Sunday, Nov 18: a. Based on results from Day 1, revise Case Plan and submit to supervisor. Submit with populated Day 1 tables.
November 22	THANKSGIVING NO CLASS	THANKSGIVING NO CLASS

November 29	Diagnostic Assessment DX3/B	2. Obtain peer review of Dx3 day 2 protocols before tabling and reporting.
December 6	Case Conference DX3/B	6. Submit peer reviewed protocols from DX3/B to supervisor for review and approval on or before Dec 6. 7. Submit first complete draft of DX3 case report for in-class case conferencing. 8. Submit DX3 case report to supervisor for grading and feedback by 11:59 pm on Friday, Dec 7. 9. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 10. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor.
December 13	Parent conference DX3	2. Conduct parent conference following approved feedback outline. Note: Parent conferences on this day may be scheduled to start at any time between 8:15-11:00 a.m. If you and your family agree on a new time for parent conference, please alert the clinic front office staff.

THURSDAY FALL 2018 CLINIC SCHEDULE
1 PM – 4:50 PM | O'Malley

Note: Timelines provided in this schedule can be modified on a case-by-case basis with supervisor approval. If your case is rescheduled due to client cancellation or absence, your supervisor will work with you to develop a revised schedule; however, it is your responsibility to independently follow your revised schedule as the supervisor will not be providing you reminders. *Requests for extensions must be approved via email at least 24 hours prior to the deadline.*

Date	Activity	Assignments
August 30	Orientation	9. Review course reader, templates, and Canvas file structure 10. Review expectations for protocols and case files 11. Review clinic expectations and sign clinic confidentiality and procedures forms 12. Complete special instruction assigned reading for Sep 6 class
September 6	Special Instruction Topic: Review & Practice Caregiver Interview Techniques for Psychoeducational Assessment Preview Diagnostic Assessment 1 (DX1)	7. Call DX1 family to introduce self, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 8. Consult with supervisor as needed regarding reason for referral and assessment protocol; 9. By 5 p.m. on Sunday, Sep 9: a. Complete Case Plan for DX1/A and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
September 13	Diagnostic Assessment DX1/A	7. Score DX1/A protocols, obtain peer review of protocol scoring before populating tables. 8. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Sep 20. 9. Complete special instruction assigned reading for Sep 20 class
September 20	Case Conference DX1/A Special Instruction Topic: Review Predicted Difference Discrepancy Analysis	5. Provide DX1/A peer-reviewed protocols to supervisor for review and approval at start of class on Sep 20 6. By 5 p.m. on Sunday, Sep 23: *a.* Based on results from Day 1, revise Case Plan and submit to supervisor. *Submit with populated Day 1 tables.*
September 27	Diagnostic Assessment DX1/B	3. Obtain peer review of Dx1 day 2 protocols before tabling and reporting.

October 4	Case Conference DX1/B Preview Diagnostic Assessment 2 (DX2)	DX1 11. Submit peer reviewed protocols from DX1/B to supervisor for review and approval on or before Oct 4. 12. Bring first complete draft of DX1 case report for in-class case conferencing. 13. Submit DX1 case report to supervisor for grading and feedback by 11:59 pm on Friday, Oct 5 14. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 15. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor. DX2 7. Call DX2 family to introduce yourself, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 8. Consult with supervisor as needed regarding reason for referral and assessment protocol (in-person, via email, or phone call); 9. By 5 p.m. on Sunday, Oct 7: a. Complete Case Plan for DX2/A and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
October 11	Diagnostic Assessment DX2/A Parent conference DX1	DX1 9. Conduct DX1 parent conference following approved parent conference plan. 10. Bring 2 copies of DX1 report for parent conference DX2 3. Score DX2/A protocols, obtain peer review of protocol scoring before populating tables. 11. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Oct 18. 12. Complete special instruction assigned reading for Oct 18 class
October 18	Case Conference DX2/A Special Instruction Topic: Guidelines for providing effective feedback & recommendations	5. Submit peer reviewed protocols from DX2/A to supervisor for review and approval on or before Oct 18. 6. By 5 p.m. on Sunday, Oct 21: a. Based on results from Day 1, revise Case Plan and submit to supervisor. Submit with populated Day 1 tables.
October 25	Diagnostic Assessment DX2/B	3. Obtain peer review of DX2/B (day 2) protocols before tabling and reporting.

November 1	Case Conference DX2/B Preview Diagnostic Assessment 3	DX2 11. Submit peer reviewed protocols from DX2/B to supervisor for review and approval on or before Nov 1. 12. Submit first complete draft of DX2 case report for in-class case conferencing. 13. Submit DX2 case report to supervisor for grading and feedback by 11:59 pm on Friday, Nov 2 14. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 15. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor. DX3 7. Call DX3 family to introduce yourself, complete developmental history interview for complete background information (obtain case-relevant information depending on referral question); 8. Consult with supervisor as needed regarding reason for referral and assessment protocol (in-person, via email, or phone call); 9. By 5 p.m. on Sunday, Nov 4: a. Complete Case Plan for DX3 and submit to supervisor. Case plan should include a thorough description of case background, noting any missing information for collection on in-person day.
November 8	Diagnostic Assessment DX3/A Parent conference DX2	DX2 & DX3/A 11. Score DX3/A protocols, obtain peer review of protocol scoring before populating tables. 12. Using clinic report template, complete background and results section with tables for all tests administered on Day 1and bring to class on Nov 15. 13. Conduct DX2 parent conference following approved parent conference plan 14. Bring 2 copies of DX2 report for parent conference 15. Complete special instruction assigned reading for Nov 15 class
November 15	Case Conference DX3/A Special Instruction Topic: Review and Practice Behavioral Strategies for Psychoeducational Assessment	5. Submit peer reviewed protocols from DX3/A to supervisor for review and approval on or before Nov 15. 6. By 5 p.m. on Sunday, Nov 18: a. Based on results from Day 1, revise Case Plan and submit to supervisor. Submit with populated Day 1 tables.
November 22	THANKSGIVING NO CLASS	THANKSGIVING NO CLASS

November 29	Diagnostic Assessment DX3/B	3. Obtain peer review of Dx3 day 2 protocols before tabling and reporting.
December 6	Case Conference DX3/B	11. Submit peer reviewed protocols from DX3/B to supervisor for review and approval on or before Dec 6. 12. Submit first complete draft of DX3 case report for in-class case conferencing. 13. Submit DX3 case report to supervisor for grading and feedback by 11:59 pm on Friday, Dec 7. 14. Complete requested revisions as requested by supervisor within 24 hours of receiving feedback until report is approved. 15. Within 24 of receiving approval of report, prepare parent conference plan and submit for approval by supervisor.
December 13	Parent conference DX3	3. Conduct parent conference following approved feedback outline. Note: Parent conferences on this day may be scheduled to start at any time between 8:15-11:00 a.m. If you and your family agree on a new time for parent conference, please alert the clinic front office staff.

COURSE CHECKLISTS

1. CONFIDENTIALITY CHECKLIST

The following checklist is meant to help ensure that you follow all client confidentiality standards.

□□Protocols do not have client names on them.

□□Take protocols home only if you really need them. Leave with them in a locked box.

□□Protocols do not leave locked box and you are always vigilant about where you take the locked box. Ask yourself: "Do I really need this here?"

□□ Reports are always de-identified and password protected on your computer. Identify final, approved report before you print it and then de-identify it again to store on your computer.

□□ All documents related to the case are de-identified and password protected. Includes parent conference, case plans, and any other documents exchanged with the supervisor.

2. PRE-REPORT PROCESS CHECKLIST

The following checklist is to be followed prior to turning your first draft of your case report in after case conferencing. Following this checklist will help ensure your report has all necessary components and is based on valid data.

□□Day 1 and Day 2 protocols have been checked by a peer and then checked by your supervisor.

□□Your tables contain all subtests administered for all assessments.

□□You have double checked your tables against your protocols, ensuring you've not made any transcription errors.

□□ All scores reported in your narrative match your tables.

□□Your report addresses all key elements laid out in the report template. Compare your report to the template guidance in order to double check that your report is consistent with the guidance provided for each section.

3. REPORT REVISION PROCESS CHECKLIST

Please carefully follow the below checklist. Points will be deducted from your final case grade if the following procedures are not followed:

□□All draft reports must not have client identifiers included. ***If a report containing negligent use of client identifiers is sent via email, a full letter grade may be deducted from your report grade.***

□□All draft reports must use the following password: eds243

□□All draft reports should follow this file naming convention:
[gradstudentlastname_case#_version#.doc] example: "Studentlastname_case1_v1.doc"

□□All draft reports subsequent to version 1 must clearly indicate draft version number
example: studentlastname_case1_**v1**.doc ; studentlastname_case1_**v2**.doc

□□Supervisor will use track changes to indicate where edits are needed in your report. After you have received your first set of revision statements from your supervisor, you must:

- ✓ carefully address every in-line edit that's been made using Track Changes
- ✓ carefully address all comments
- ✓ **do not delete earlier comments or in-line edits** made by your supervisor; leave them in the text until the report is approved for printing
- ✓ Never send a report to your supervisor as a second or third draft without earlier comments and in-line edits incorporated.

□□Your first draft is due to Supervisor by midnight on the day after case conferencing (so if Case Conferencing is Thursday, then your draft is due Friday at midnight). Subsequent revision drafts are due within 24 hours of receiving your report back from Supervisor (so if you receive your report back on Saturday at 11 a.m. then it is due back to Supervisor at 11 a.m. on Sunday). Exceptions will be granted for special circumstances, but must be discussed with Supervisor prior to the due date/time. Please confirm with your supervisor expected due dates and times.

□□Only after receiving notice from Supervisor that your report is "approved for printing" will you do the following:

- ✓ Accept all in-line edits
- ✓ Remove all comments
- ✓ Complete a thorough copy edit
- ✓ Review the report formatting to eliminate any hanging sub-headers or other unflattering formatting problems based on supervisor preference
- ✓ Print two copies for signature

□□Bring your final printed copies to clinic on the day of parent conferences and leave them out for Supervisor to review and sign while you are doing your next assessment.

CCDS School Psychology Case Completion Checklist

It is the school psychology graduate student's responsibility to turn in a complete record of the assessment. The CCDS staff will not accept a file as complete until the following are completed:

Double hole punch every document and place them in the following order from bottom to top:

- ☐ Request for services / referral sheet (Pink Slip)
- ☐ Consent to Treat (Signed by parent, student clinician, and supervisor)
- ☐ Completed Clinic Questionnaires (teacher and parent)
- ☐ School records provided by parent (include only those referenced in the report)
- ☐ Protocols (Cover page of every protocol includes all called for information, including but not limited to the full name of client, full name of assessor, and any collected data
- ☐ Psychoeducational Evaluation Report (Supervisor-approved version complete with copy edit, with supervisor signature)

Graduate Student Signature: _____ Date: _____

Clinic Staff Signature: _____ Date: _____

Tips for Interpreting & Reporting on Social/Emotional/Behavioral Rating Scales

Interpreting

- Determine if the clinic has electronic software for the rating scale.
- Complete scoring by hand or electronic.
- Have a peer double check scoring.
- Table all your scores using appropriate templates. If you do not have access to a template, notify your supervisor and your peers to determine if anyone else has one.
- Within your table, denote for the reader elevated scores. This can be done in various ways, depending on your style and the preference of your supervisor (e.g., * for moderately elevated and ** for highly elevated)
- To organize your thoughts, use a separate document to note for yourself patterns of elevated and highly elevated scores across raters. The table below is an example using the BASC-3 scales.

Rater	Elevated / At-Risk	Clinically Elevated
Mom	Depression Social Skills	Anxiety Withdrawal
Dad	Withdrawal	Depression Anxiety Social Skills
Teacher 1	Attention Problems Anxiety Withdrawal	Depression
Self	Depression	Social Stress Anxiety Sense of Inadequacy

- After you have examined the scores in this way, write a few sentences that *summarize* trends in the ratings. An example from the above is:
  - All raters note concerns around depression and anxiety.
  - Teacher notes concerns around client's attention in the classroom.
  - Client and parents note concerns around social stress and withdrawal.
- After you have written a few summary sentences, weave them together to form a coherent clinical statement. *Note that doing this part takes a lot of practice and your supervisor will typically need to guide you to help you with writing effective summary statements. The most important piece when you are new to this is that you correctly identify the trends in reporters' ratings.* An example for the above would be:
  - "Ratings are relatively consistent across home and school settings. XXX's mother, father, and teacher report elevated concerns around Depression, Anxiety, and Withdrawal, as well as deficits in Social Skills. These reports are consistent with XXX's self-report. She noted elevated concerns in Depression, Anxiety, Social Stress, and a Sense of Inadequacy. The results are consistent with parent referring concerns and with teacher written reports. Often children who experience worry and sadness find it challenging to

stay focused in class and other settings. Furthermore, these negative feelings are likely contributing to her ability to successfully engage in day-to-day tasks."

- Finally, start to write your narrative. See below for reporting guidelines.

Reporting

- Include name and purpose of rating scale as defined by publisher.
- Describe descriptive ranges of T-Scores of other rating statistics.
- Include well-designed and easy-to-interpret table with all scores. If the electronic rating scale program gives you graphs, you may copy and paste these into your report. Your supervisor has discretion to remove if preferred.
- Include the narrative statement that you drafted using the guidelines above.
- Attend carefully to formatting:
    - Capitalize and italicize name of rating scale [e.g., *Behavior Assessment Scale for Children, Third Edition (BASC-3)*]
    - Capitalize subscale test names (e.g., Attention Problems, Depression, Withdrawal)
    - Capitalize classification ranges (e.g., Average)

TIPS FOR WRITING AN EFFECTIVE SUMMARY SECTION

Paragraph 1:

- Restate the client's name, age, and school site name.
- Restate reason for referral in one or two sentences.
- Restate test validity in one sentence.

Paragraph 2:

- State relevant test day observations (the degree to which you cover behavioral observations in the summary depends on how important they are to the clinical conclusion, range is typically 2-4 sentences).

Paragraph 3 & 4:

- State major findings from cognitive assessment-overall cognitive abilities and major strengths and weaknesses (3-4 sentences).
- State major findings from achievement tests-major strengths and weaknesses (3-4 sentences).
- State major findings from psychological processing tests -major strengths and weaknesses (3-4 sentences).

Paragraph 5:

- Summary statement about diagnostic implications (2-3 sentences).
- Caveat about clinic setting and limitations of this assessment (1 sentence).

Tips for Success in Diagnostic Clinic
By: Meagan O'Malley

Welcome to diagnostic clinic! The purpose of diagnostic clinic is to build your skills for identifying referral questions, developing effective case plans to address referral question(s), effectively using a variety of tests available in the clinic library, and writing technically adequate case reports.

Access to the diagnostic clinic is a privilege. The university has invested in the clinic materials and staffing to ensure that graduate students get excellent training. In fact, the CSUS School Psychology program is one of very few programs in the state that has a diagnostic clinic.

To ensure that you get the most out of your diagnostic clinic experience, do the following:

1. **Follow clinic procedures.** The clinic director (Mr. Michael Levine) will give you clear directions on procedures for functioning in the clinic setting. School psychology graduate students are responsible for carefully following all clinic procedures. Clinic procedures involve rules for maintaining client confidentiality, rules for managing case files, rules for checking out test kits and other materials, and rules for using the clinic facilities. Also, and perhaps most importantly, be *pleasant and professional with all clinic staff at all times*.

2. **Follow supervisor directions.** While all supervisors vary in style, we all tend to have a standard set of directions. While you are a trainee, you must follow all directions provided by your supervisor. This includes, but is not limited to: carefully attending to timelines, reading all guidance documents provided via email and in Dropbox (or other electronic system used by your supervisor), using approved templates only, following checklists provided by supervisors, and carefully incorporating written and oral feedback into current and future practice. The expectation is that you will become independent in using the tools provided to you by your supervisor; after your first case, reminders to use supervisor-provided tools should not be necessary.

3. **Pay attention to detail.** Careful attention to detail is one of the key characteristics of an excellent school psychologist. Diagnostic assessment includes many, many details that need to be considered. You must use all standardized procedures for all test batteries, accurately score your protocols, accurately transcribe your scores into your reports, accurately interpret scores, and so on. Ways that you can ensure you are attending to detail include: have a trusted peer double score all your protocols; ask a peer to double check your transcription before you start analyzing your data; work on your reports one section at a time, taking breaks between; print your reports and read them aloud, monitoring for errors in sentence structure; have a peer read your completed report to look for errors. Build in a hefty amount of time in your schedule to allow for your work on diagnostic-related tasks to be done thoroughly and completely.

4. **Be open to feedback.** Diagnostic clinic may be the first time that you receive one-to-one feedback on your assessment skills, report writing skills, and communication skills. It is critical that you maintain an attitude of openness and willingness to incorporate feedback. Remember, your clinic supervisors are on your team—our feedback is designed only to make you the best school psychologist you can be. What you learn in clinic you will use for the remainder of your career. Remind yourself to see our feedback not as a threat, but as an opportunity.

5. **Get comfortable with discomfort.** No two cases are alike. This means that you will learn new things on every case, and it also means you will be continuously getting new feedback from your

supervisor. Just when you think you've got it mastered, you'll find out there was something you didn't know. Get comfortable with this—it's just part of the process. Also, remember that we are working with people who are living complex lives, and that means we have to be prepared for clients to sometimes cancel appointments, be difficult to reach via phone, forget to return rating scales, or do other things that create hiccups for the assessment process. We have built in enough flexibility in the course schedule to allow for these kinds of challenges to occur. Your supervisor will work with you to develop realistic solutions for any curveball that may come your way. Just breathe and consult with your supervisor.

6. **A point gained is a point earned.** It is important to remember that we selected you for this program because we felt you had the skills and disposition to be an effective graduate student in school psychology. A-level grades are earned in graduate school. Remember: *You begin each case with zero points, and each point gained is a point earned.*

7. **Be present and maintain a positive orientation toward clients.** Sometimes you will feel stressed or tired. Sometimes you will have things going on in your personal life that are weighing on you. This is all a normal part of life, and we don't expect that all your personal life disappears when you are working in the clinic. That said, it is critical that when you are working with clients, you practice mindfulness and presence and that you maintain a positive, helping stance. If you feel that you cannot be wholly present for your client, please alert your supervisor in advance so that an adjusted plan can be made.

8. **Consult, do your own independent learning, and consult some more.** Success in diagnostic clinic requires that you pursue knowledge regularly, both by regularly working with your supervisor and also doing your own independent research. Independent research on a case might mean reading the related empirical literature, talking with your peers, and consulting with your field supervisor or other school psychology faculty. That said, you must always bring your independent research back to your clinic supervisor for consultation and, ultimately, approval of your case interpretation. Similarly, it is critical that you maintain regular communication with your clinic supervisor via whatever communication routes the supervisor prefers. If you are worried that you are "bugging" your supervisor, relax and remember: It is always better to over-communicate than to under-communicate.

PSYCHO-EDUCATIONAL REPORT EVALUATION FORM

	AVAILABLE POINTS			OBTAINED POINTS
Evaluation Categories/Items	**Major Revision Required**	**Minor Revision Required**	**Acceptable**	
Fundamentals/Identifying Information and Reason for Referral (5)				
1. Includes appropriate identifying information with necessary detail.	0	2	3	
2. Referral question clearly stated and well defined.	0	3	6	
Background Information (14)				
3. Appropriate detail of relevant educational history and present school performance.	0	2	3	
4. Sources of information are consistently reported.	0	2	3	
5. Appropriate detail in areas of family history, social-emotional functioning, and prior evaluations.	0	2	3	
6. Appropriate detail in areas of developmental and health history.	0	2	3	
7. Vision and hearing stated and date of last exam, and results reported.	0	2	3	
8. Current prescribed medications (name and dosage)—and whether medications were taken on assessment date--are described.	0	2	3	
Behavioral Observations (13)				
9. Ease of establishing and maintaining rapport, client temperament and activity level clearly described.	0	2	4	
10. Behavioral observations are appropriate for the case presentation, including appropriate emphasis on attention/motivation, problem solving strategies, anxiety, and work habits/effort.	0	2	4	
11. Clinician interpretations are substantiated with examples of specific behaviors, and subjective comments are avoided.	0	2	4	
12. Relevant language issues, motor issues, and cultural considerations are described.	0	2	4	
Reporting Test Results (18)				
13. Includes clear and detailed validity statement.	0	1	2	

14. Confidence intervals explained and correctly included throughout report.	0	1	2	
15. Statistical interpretations and descriptors are accurate throughout report.	0	4	8	
16. Demonstrates clear understanding of results.	0	5	10	
Interpretation of Test Results-Summary, Conclusions (8)				
17. Summary emphasizes salient aspects of the assessment.	0	4	8	
18. Summary includes effective synthesis of data.	0	3	6	
19. Conclusions directly connected to referral question and address it.	0	3	6	
20. Strength-based information included and integrated in detail.	0	2	3	
Recommendations				
21. Recommendations are developmentally appropriate.	0	3	5	
22. Recommendations are evidence based.	0	3	5	
Writing Quality, Attention to Detail (42)				
23. Draft report is submitted free of client identifiers. (A)	0	2	3	
24. Draft report revisions are submitted on time. (B)	0	2	3	
25. Writing is free of spelling/grammatical/tense errors.	0	3	5	
26. Jargon is minimal, and when used is defined and accurately explained.	0	3	5	
27. Writing is logical and coherent.	0	4	8	
28. Report requires supervisor input that is appropriate to current level of training.	0	4	8	
SUM OF RATINGS				0
Points Available (auto set to 130, must hand enter if other)				130
Report Score				0
COMPLETE draft available at case staffing (B)	**YES**	**NO***		
(A) Negligent use of client identifiers or errors in scoring will result in up to a full letter grade deduction for the report.				
(B) Reports that are not turned in on time will result in the reduction of a full grade for every 24 hours from the time it is due.				

TEST PLANNING & ADMINISTRATION EVALUATION FORM

	AVAILABLE POINTS			OBTAINED POINTS
Evaluation Category/Item	**Major Revision Required**	**Minor Revision Required**	**Acceptable**	
Case Planning				
1. Case Plan submitted with appropriate detail and on-time.	0	4	8	
2. Case Plan is adequate for current level of training (e.g., level of independence with test selection).	0	3	6	
Day-Of Preparation				
3. Explains limits of confidentiality and review role of CCDS as teaching clinic to parents.	0	1	2	
4. Clinician arrives well prepared for clinic testing day: appropriately dresses, has materials prepared, clear understanding of aims of the testing day.	0	3	6	
Test Administration				
5. Administration follows approved Case Plan. Seeks supervisor approval before deviating from case plan.	0	2	4	
6. Carefully follows standardized test procedures as defined by each test's developer.	0	8	15	
7. Fluid administration that keeps rhythm appropriate to child's response speed and attention span.	0	4	6	
Rapport With Client				
8. Demonstrates social engagement appropriate for the client's developmental level.	0	2	4	
9. Demonstrates consistent attention to client personal and emotional needs.	0	2	4	
Protocol Scoring				
10. Protocol scoring is accurately completed.	0	3	5	
11. Scores are accurately transcribed from protocol to report.	0	3	5	
SUM OF SCORES				0
Total Possible Points (auto set to 65, must hand enter if other)				65
Test Day Score				0
(A) Negligent use of client identifiers or errors in scoring will result in up to a full letter grade deduction for the report.				

PARENT CONFERENCE & CASE CLOSURE EVALUATION FORM

	AVAILABLE POINTS			OBTAINED POINTS
Evaluation Category/Item*	**Major Revision Required**	**Minor Revision Required**	**Acceptable**	
Preparation				
1. Parent Conference Plan submitted with appropriate detail and on-time.	**0**	**4**	**6**	
2. Clinician is prepared on-time with signed reports, and room is set up for parent conference.	**0**	**4**	**6**	
Rapport With Parents				
3. Introduction explaining limits of confidentiality, purpose of assessment, and structure of feedback session.	0	2	4	
4. Ability to present information in a way that reflects understanding of parent concerns and respond in an organized and emotionally present manner to parent emotions.	0	4	6	
Ability to Provide Feedback in an Understandable Manner				
5. Jargon-free, clear, and effective presentation of results, including a clear explanation of the referral question.	0	4	6	
6. Discussion was concise and focused.	0	2	4	
7. Accurate explanation of test results and implications conveyed.	0	5	10	
8. Clear explanation of recommendations.	0	2	3	
Effective Response to Questions				
9. Responses to questions based on research/accepted body of knowledge.	0	2	3	
10. Provision of resources and/or suggestions where parents may find information.	0	2	3	
Case Closure				
11. Procedures for case file closure are carefully followed, including completed protocols with all client identifiers. (A)	0	2	4	
SUM OF SCORES				0
Available Points (Set to 55, must hand enter if other)				55
Total Parent Conference Score				0
(A) If files are found to be incomplete, a grade reduction may result.				

CCDS Diagnostic Clinic Test Day Planning Form: DX# _____

Client Age (years, months)		**Clinician**	
Grade Level		**Clinic Dates**	

Background information:

- Using bullet points, note background information relevant to the case conceptualization (e.g., developmental history, academic history, family history).

Referral Issue(s):

- Provide referral concern noted in referral form and confirmed via parent interview.
- Although parents may have more than one concern, work with parents to identify a primary concern given time constraints.
- Define the referral in observable terms.

Objectives/Desired Outcomes for this Case:

- Specify what your assessment will inform (e.g., "To help clarify client's diagnosis and provide information to the family regarding the diagnostic implications.")

Working Hypotheses to be Tested Regarding Referral Issue:

- ***Hypothesis 1:*** Based on your current understanding, specify what you believe will be the potential outcome(s) of your assessment **(**e.g., "Client's difficulties in academic functioning may be due more to verbal delays and attention difficulties as opposed to a diagnosis of SLD.")

Clinician's Professional Development Goals for this Case:

- Include your professional goals **(**e.g., "Learn to administer a nonverbal cognitive testing battery.")
- Specify any areas you would like supervisor feedback to focus on.

Agenda for Test Day 1:

- Give a timeline of your test day plan. Include all composites you plan to compute based on your assessment (note: Don't just say "WISC-V," say "FSIQ, VCI, PRI, PSI, WMI, NVI"). One Specific Activity per line. For example, …

Activity	Time Activity Will Begin & End
Brief meeting with parents: review confidentiality, obtain records, provide behavior rating scales	8:30 – 9:00 am
WISC-V administration: VCI, FRI, PRI, PSI, WMI subtests	9:00 am – 10:30 am

Agenda for Test Day 2:

- Give a timeline of your test day plan. Include all composites you plan to compute based on your assessment (note: Don't just say "WISC-V," say "FSIQ, VCI, PRI, PSI, WMI, NVI"). One Specific Activity per line. For example, …

Activity	Time Activity Will Begin & End
Brief meeting with parents: obtain records and behavior rating scales	8:30 – 9:00 am
GORT2	9:00 am – 10:30 am

Rationale for Selecting Measures:

- For measures other than cognitive and academic achievement, indicate reason for selecting testing measures, include at least 1 peer-reviewed reference that describes how your measure applies to your case. The Measurement Yearbook, which can be found on the campus library webpage, is an excellent resource.
- Include psychometric properties (i.e., reliability and validity) of each test battery selected.

Parent Conference Template

Directions: For each section below, provide bullet points of key points you intend to make during your parent conference. If your supervisor prefers (or you prefer), you may write out a full scripted narrative as you see in the examples below.

1. **Introduction (2.5 minutes):** (welcome, positive child comment, time for meeting, test validity and limitations)
   Example: Good morning! It is great to see you again. My name is EXAMINERNAME and I had the privilege of working with XXX and administering a comprehensive assessment to help determine his strengths, weaknesses, and overall functioning. At the time of referral, specific concerns included XXX's general lack of knowledge and academic performance, specifically in reading and writing. From these referring concerns, the following suspected areas were evaluated by this assessment: cognitive functioning, academic achievement, and phonological processing.

2. **Explain the meeting (2.5 minutes):** (give overview of what the parent can expect from the meeting)
   Example: Today we have about 20 minutes to review and discuss the results from the assessment. I will spend about 10-15 minutes reviewing the results and I will leave time for further questions and discussions.

3. **Behavior during testing (2.5 minutes):** (start with positive things, give clinically relevant observations)
   Example: I really enjoyed the opportunity to work with XXX. XXX was focused, attentive, well-mannered and appeared to put forth his best effort throughout assessment tasks. He appeared slightly frustrated when items became more difficult. For example, when asked to provide a word with a specific phoneme, he appeared frustrated when he could not think of a word. Overall, XXX persisted with difficult tasks and appeared to put forth his best effort. While XXX suffers from sleep apnea and seasonal allergies, these factors did not appear to adversely affect his performance. From his behavior during testing, the scores obtained during XXX's evaluation are considered to be a valid estimate of his current functioning in the domains assessed by the tests administered.

4. **Validity/ Limitations (2.5 minutes): (**overview of confidence intervals, whether the test was considered valid for the client)
   Example: A degree of error exists with all standardized measures. Scores should be considered as falling within a range of scores to account for measurement error. To account for this error, I used a 90% confidence interval. This means if XXX were to return and take this assessment on any other given day, 9 times out of 10 his score would fall within this range.
   (Show normal curve) This is a visual of a normal curve, which represents the population. If we were to look at a sample of 100 students about 50% of students fall within the average range with some students falling above and some below. All of the scores I present to you today fall within this distribution. These test results are considered valid for XXX.

5. **Discussion of Results (10 minutes)** (major findings, use graphics, begin with strengths):
   Example:
   Cognitive Assessment: I used the Woodcock-Johnson IV to assess XXX's overall cognitive abilities. *Show table* The WJ-IV COG yields a General Intellectual Ability (GIA) from seven differentially weighted subtests. It also yields several composite scores (indicated on the table), which allow us to identify strengths and weaknesses within the student's specific cognitive abilities.

Normal curve On the WJ-IV COG, XXX obtained a General Intellectual Ability (GIA) score of 112 (the confidence interval is 106 to 118), which falls in the Average to High Average ranges and he performed better than or equal to 79 percent of same-age peers. Specific areas of cognitive functioning also fell within the Average to High Average ranges.

Academic Assessment: XXX's academic achievement as measured by the WJ-IV ACH is congruent with his cognitive abilities as he performed in the Average to High Average ranges across all clusters including reading, mathematics, and written language. XXX demonstrated a weakness on Passage Comprehension (Low Average range), which suggests slight difficulties comprehending written text.

Discrepancy Analysis: When comparing XXX's predicted and actual achievement, in most areas, XXX is performing better than expected given his cognitive abilities. XXX's cognitive abilities and academic achievement suggest he is capable of performing as well as or better than same-age peers.

Processing Measures: *Normal Curve* Results from the CTOPP-II indicate XXX's phonological processing abilities fall within the Low Average to Average ranges. XXX's performance across composites of phonological processing is consistent with measures of auditory processing on the WJ-IV COG. XXX is aware of and has the ability to access the sound structure of oral language and is able to retrieve phonological information from memory similar to same-age peers. Well-developed phonological processing abilities are foundational for reading. XXX's performance is also reflected on achievement measures of reading, which indicates his reading skills are similar to or better than same-age peers.

Social-Emotional Measures: *Graph* Regarding social-emotional concerns, you (parent) reported slight concerns on the BASC-3 in the areas of Externalizing Problems, specifically Aggression, and Internalizing Problems.

Regarding adaptive behavior, XXX's overall adaptive functioning fell within the Average range; however, ratings of Adaptability and Functional Communication fell within the At-Risk range. Your ratings (parent) were congruent with the parent interview and Parent Questionnaire.

Previously, XXX had difficulties managing his anger, but has matured emotionally and behaviorally. It is not uncommon for children experiencing multiple transitions to have difficulty regulating their emotions as they adjust to new environments and expectations.

XXX currently works with a psychologist and has made tremendous growth by learning more effective ways of managing his anger problems and regulating his emotions, which is reflective on measures of adaptive functioning.

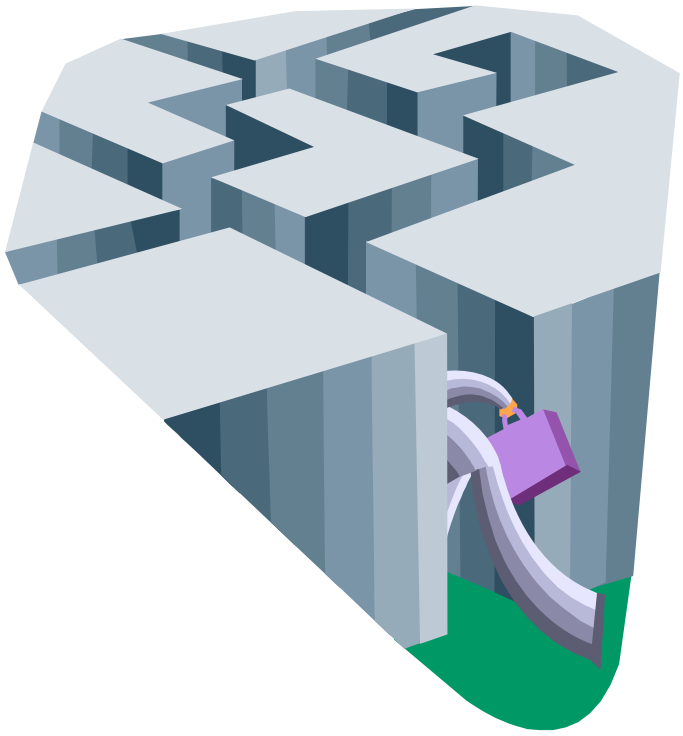
6. **Conclusions (2.5 minutes)** (repeat main finding, any further recommendations, questions)
Example: Overall, XXX's performance across a wide array of cognitive, academic, and processing tasks suggest XXX's abilities are relatively congruent with same-age peers. In most areas, XXX's performance indicates he is capable of performing better than expected given his cognitive abilities. XXX's referral concern of past academic difficulties may have resulted from major transitions in his life or lack of effort. Currently, XXX appears to be performing well in school. The therapeutic and educational opportunities provided over the past two years appear to be of great benefit to XXX and likely support his academic and social-emotional skills.

It is important to remember that test scores are only one sample of XXX's behavior under controlled conditions. XXX's guardians are encouraged to continue working with his classroom teacher to provide the appropriate support XXX needs to be successful. I have provided a list of appropriate recommendations to address XXX's specific needs including:

- To further support XXX's weakness in comprehension, encourage him to highlight the text and take notes as he reads.
    - For example, encourage XXX to write notes and questions in the margin, circle words he does not know, and highlight main ideas. *Provide handouts*
- To increase XXX's motivation to complete assignments consider implementing a contingency contract in the home and school setting. Identify activities or items XXX enjoys and use these interests to motivate and reinforce XXX. Reinforcement can be an event or tangible item he will strive to earn.
    - For example, options could include earning time to watch football, play Pokemon GO!, or additional time playing with friends.
    - Reinforcement must be immediate and contingent on XXX's performance of desired behaviors. (e.g., "**When** you complete your homework, **then** you will get to play Pokemon GO!") *Provide handout*

7. **Closing (1 minute):** (thank the parents for coming, give information about how to get more information if questions arise later)
   Example: It was a pleasure to meet and work with XXX. Thank you for the opportunity! Here is a copy of a comprehensive report. If you have any questions, please feel free to contact the clinic, they will contact me and I hope to answer any questions you may have.

CLINIC-PROVIDED DOCUMENTS FOR INITIAL CONSIDERATIONS



CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION
AND SCHOOL PSYCHOLOGY
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

PARENT CLINIC APPOINTMENT LETTER

Dear Parent,

Your child is scheduled for an appointment in the School Diagnostic Clinic. Our goal is to provide you with information that will be useful in future educational planning. To that end we ask the following:

- ✓ Please complete the attached parent questionnaire form and return it to the clinic before your appointment.
- ✓ Please ask your child's current teacher to complete the attached teacher questionnaire and return it to you to bring to the clinic or return it to the clinic in the envelope provided. If your child has been with his or her current teacher for less than one month, please give the form to last year's teacher.
- ✓ The testing appointment is long and can be tiring for children. So that your child is able to do his or her best please make sure that he or she has eaten before coming to the clinic. A good night's rest is also important.
- ✓ Let your child know that he or she is coming to the clinic for the evaluation. Most children really enjoy the process and find it different from, and usually more fun than, schoolwork.
- ✓ Please be sure to inform the examiner about any concerns or special issues that might affect test results.
- ✓ If you have any previous testing or school records for your child (e.g. report cards, previous evaluations) please bring them with you to the first appointment and be prepared to leave them at the clinic for one week.
- ✓ Please make sure you arrive in plenty of time to deal with limited parking. Any delays will interfere with your child's evaluation time.

We are looking forward to meeting you and your child and hope to be of service to you. Please call the clinic at 916 278-6252 if you have any further questions.

Thank you,

School Diagnostic Clinic staff

TEACHER QUESTIONNAIRE

Dear Teacher,

Your student _____, has been referred to the School Diagnostic Clinic at California State University, Sacramento, for a diagnostic evaluation. To help us with this evaluation we would appreciate the following information. Thank you very much for your cooperation: your input is very important to us.

What would you consider to be this student's strengths?

What is the student not doing now that you would like her or him to be able to do?

How does this student compare to other students in your class? (e.g. low average in reading, above average in math, below average in work completion)

What modifications have you tried? How has the student responded?

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION
AND SCHOOL PSYCHOLOGY
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

PARENT QUESTIONNAIRE

Child's Name: _____ Birth date: _____

School: _____ Grade: _____

Parent(s): _____

Home phone: _____ Alt. Phone: _____

Languages spoken in the home: _____

Siblings and their ages: _____

Have there been any recent changes or events in your family that may have impacted your child (e.g. moves, deaths, separation/divorce)? _____

_____

Has your child been evaluated or referred for special education assessment? YES NO

(IF "YES") What was the reason for the referral? _____

_____

What do you see as your child's strengths at home and at school? _____

_____

What concerns bring you here at this time? _____

_____

Were there any pregnancy or delivery complications (if so, please describe)? _____

_____

At about what age did your child start to do these things?

_____Walk _____First Words _____Short sentences

_____Use the toilet independently _____Use utensils independently _____Play with others his age

Are there any health concerns (vision, hearing, medication, ear infections, allergies, high fevers, etc.)? ___

_____

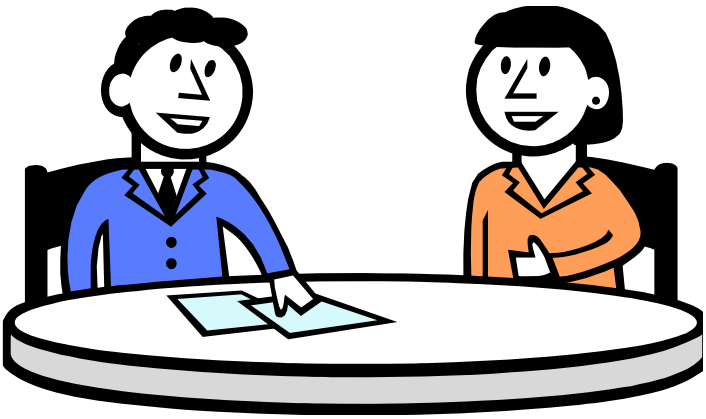
_____

Have there been any accidents, surgeries, or hospitalizations? _____

_____

How would you describe your child's social and emotional development? _____

MEETING WITH PARENTS



THOUGHTS ON THE PARENT CONFERENCE

by Catherine Christo and Stephen Brock

Prerequisite to holding the parent conference is planning what you are going to say. This means understanding what you are talking about, having all materials you think you might need available, and planning what you are going to say. Early in your career, this planning should always involve rehearsal. Literally, talk it through for yourself.[1] As you prepare for your conference always try to anticipate and prepare for possible parent questions (especially the hard ones).

Once the conference begins, before presenting your assessment findings, comment on test validity and the limitations of the procedures you used. Your observations of test taking behaviors should be shared with the parent and a conclusion offered regarding the accuracy of the obtained estimate of the child's skill/ability levels. Some specific comments that you may want to offer about limitations include: (a) among children under the age of 7, the predictive power of IQ tests is low; and (b) psychometrics are samples of behavior that do not take the place of the knowledge gained by working with a child over a prolonged period of time. Always avoid overstepping your test information. For example, remember that parent reports are their *interpretations* of what happens for their child at school, not always objective fact. In addition, you should always avoid overstepping your knowledge base. For example, if a parent asks about a medical matter refer him or her to the child's doctor. If a parent question asks for information that a school psychologist might be expected to have, but the knowledge is not yet in your knowledge base (something that is to be expected of a psychologist in training), then let the parent know you will research the question and get back to him or her.

The beginning of the conference should also include a comment or two about your experiences working with the child. If the child's test taking behavior was strong, this is often a good time to say something positive about the child (e.g., "Your son/daughter was a very hard worker and I really appreciated his/her effort"). If at all possible, always find a way to comment either on one of the child's strengths or something else that the parent can relate to. Doing so will help to make the parent feel that you really know their child and that you are not simply reporting test scores.

Second, after offering the introductory comments, "front-load" your presentation with your main assessment finding(s). Typically, this is your response to the referring concern. For example, if the referring concern related to whether or not the child had dyslexia, you might begin by saying; "From the available assessment data I have concluded that your child does have a reading disability." Alternatively, keep in mind that if your assessment did not find support for the referring concern, you should so indicate. In such instances parent conferences will be relatively brief. Quite simply, there will not be as much to say.

Next, review the assessment findings that lead to your conclusion(s). Try to avoid telling parents what they already know, unless you need to do so to confirm something. For example, parents know their child's health and school history. In addition, resist the temptation to review all tests and subtest with the parent and DO NOT READ THE REPORT TO THE PARENT. Rather, with the report closed and in your lap, highlight those findings that relate directly to your main findings. For example, in the case of an assessment that has identified a reading disability you will want to acknowledge the following: (a) achievement test scores demonstrate a deficit in specific reading skills, (b) intelligence test results have ruled out cognitive deficits as a cause of the reading difficulties, and (c) there are basic psychological processing disorders that explain the reading deficits. Your discussion of the basic psychological processing disorders will typically be relatively detailed. Here it will be appropriate to review performance on specific tests and subtests to help the parent better understand how you identified the child's difficulties. While we do suggest that you

[1] As you become more and more experienced, such practice will become less important.

avoid details, we do expect that you will be prepared to address such if asked. For example, it is expected that you will be prepared to discuss what specific subtests measure.

Parents are greatly helped by visual aids. You may give the parents their copy of your report and refer to specific results if they seem confused. In addition, you may give them a copy of a bell-curve handout to help them better understand the meaning of standardized test scores.

Finally, summarize the important information for parents in a succinct manner that highlights your response to their question. For example, you might state: "Your child may have a learning disability and I recommend that he be evaluated by the school to determine if there is a need for special education assistance." In addition to giving parents the information most relevant to the referring concerns and main assessment findings, it is also important to figure out how **not** to engage in extended conversations. It is okay to say, "You know that is a really important issue, but I am not the one to discuss it with." And then go on to provide other resources, whether the clinic counseling or an outside resource of some sort. Another suggestion for limiting the conference, if you think it might be extended, is to set the limits up front. "We have about 20 minutes for our conference. I will spend about 10-15 minutes reviewing the results with you and that will leave another 5-10 minutes for any further discussion."

To further assist you in planning for your parent conference, a "template" for conducting a parent conference is offered on the following page.

TEMPLATE FOR CONDUCTING A PARENT CONFERENCE

Welcome parents and explain purpose/limits of the conference: _____

Test validity/limitations: _____

Main assessment finding(s): _____

Summary: _____

Recommendations: _____

UNDERSTANDING PSYCHOLOGICAL TEST SCORES

By Dorothy Marshall, Ph.D.

Tests your child takes at school are usually scored by counting the number right or wrong; sometimes this is reported as a percentage, as in "I got 100% on my spelling test!"

The tests used in this evaluation are scored differently. Your child is compared to a large sample of children of either the same age or grade. This group, called the **norm group,** has been carefully chosen to reflect the general population of the United States. The scores on any one test will tell you if your child's performance was like most of the students in the norm group, or whether he or she is doing better or poorer than the average child.

These normative scores can be expressed by different scales. The most common scales, called **Standard Scores,** set the average score equal to **100.** Higher scores mean your child is better than average, while lower scores indicate that your child may at a disadvantage in the ability being measured by the test. Usually scores from **90 to 110, or 85 to 115** are defined as average. On overall cognitive tests, scores **above 130** are considered "gifted," while scores **below 70** suggest delayed development or "intellectual disability."

Standard Scores are most commonly used when describing results of an entire test, or groups of abilities. The tests we give are usually a combination of smaller subtests which are combined to give an overall score. The subtest, or **Scaled Scores** are often reported on a different scale, with the average score set at **10**, and **8 to 12, or 7 to 13** considered to be the average range.

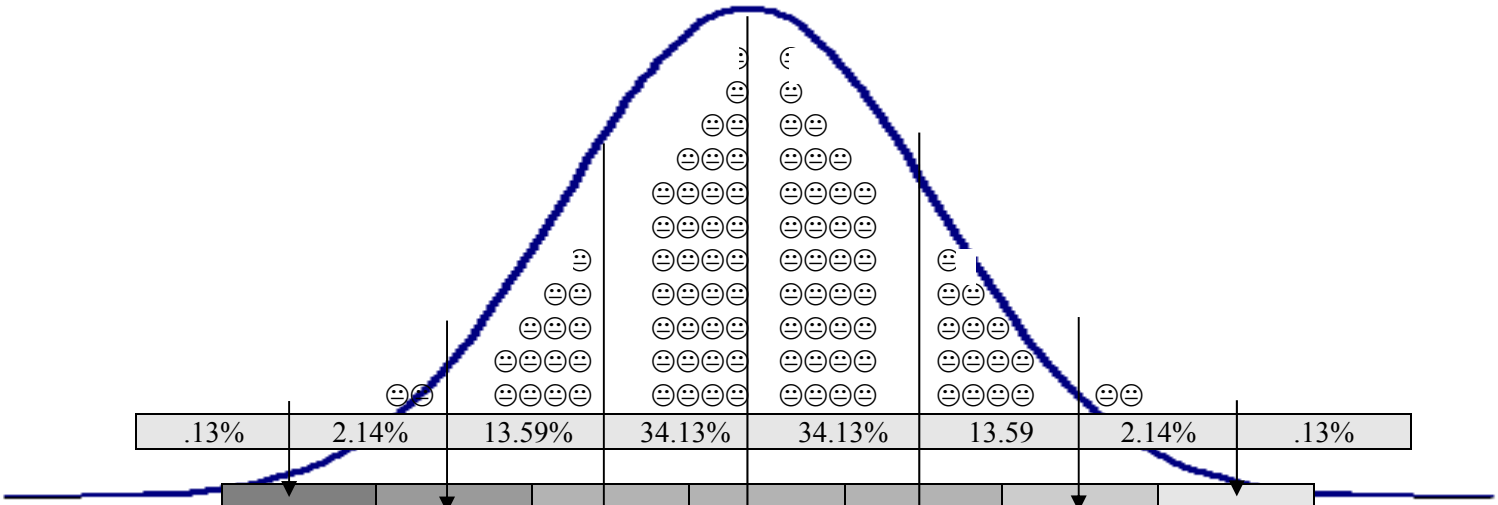
Percentiles (not percents) are another way of comparing your child's test results to a norm group. Scores are ordered from highest to lowest, and the **50th percentile** is the average score. The higher the percent**ile,** the better the score. Imagine 100 people lined up according to height. If you start counting from the bottom, the 50th person will be at the 50th percentile, or average height. The 90th person will be taller than 89 of the people in line and their score will fall at the 90th percentile. If you are the 30th person in line, you will be taller than 29 out of 100 persons and you will be at the 30th percentile in height.

Because psycho-educational testing is based on a sample of behavior, all tests have some measurement error. You child's score may change depending on how he or she was feeling that day, how well he got along with the person testing, or how distracted she was by things happening in her life. However since the test is always given in the same way, we can be reasonably confident that were your child to be tested again, the score would fall within certain limits. These limits are known as **confidence intervals.** A 90% confidence interval means that we can be 90 percent confident that your child's test score will fall within these limits.. The **confidence interval** is given in parentheses after the obtained score. For example, "*Katie's ability to solve practical math problems was above average, with a Standard Score of 117 (112-123)."*

All the scores described here are based on a comparison or **norm group**. The norm group represents a cross section of U.S. children of the same age or grade. Comparison to a norm group gives meaningful scores only if your child's background and learning opportunities are similar to most of the children in the norm group. If your child has had a very difficult or different upbringing; if his or her culture and language are different, the examiner must chose tests very carefully in order to be fair to the child. If this is not done, the test may be invalid; that is the test is not measuring what it is supposed to measure. Tests can also be invalid if the child is resistant, or unable to pay attention. Your test report should always include a statement about the **validity** of the scores obtained.

DESCRIPTIVE STATISTICS AND PSYCHOLOGICAL TESTING

By Stephen E. Brock, Ph.D., NCSP
California State University, Sacramento



	-3sd	-2sd	-1sd	Mean (Median & Mode)	+1sd	+2sd	+3sd	
	Below Average	Low Average	Average			High Average	Above Average	
Z-Score	-3	-2	-1	0	+1	+2	+3	Z-Score
IQ Score	55	70	85	100	115	130	145	IQ Score
T-Score	20	30	40	50	60	70	90	T-Score
Scaled Score	2	4	7	10	13	16	19	Scaled Score
%ile	1	2	16	50	84	98	99	%ile Rank
Rank	1 99		10	20 30 40	50 60	70 80	90	

NOTE: *Z*-scores, IQ scores T-scores, and scaled scores are considered interval scales of measurement. These scores indicate rank and meaningfully reflect relative the distance between scores. Percentiles only indicate ranking, by themselves they do not indicate how far apart scores are.

The Normal Curve

The normal curve is a hypothetical distribution of scores that is widely used in psychological testing. The normal curve is a symmetrical distribution of scores with an equal number of scores above and below the midpoint. Given that the distribution of scores is symmetrical (i.e., an equal number of scores actually are above and below the midpoint) the mean, median, and mode all fall at the same point. Since many psycho-

educational measurements (e.g., intelligence and achievement test scores) assume a normal distribution, the concept of the normal curve is very important to school psychologists.

If we divide the distribution up into standard deviations from the midpoint, a specific percentage of scores will lie under each part of the normal curve. As illustrated in the figure above, 34.13% of the scores lie between the mean and 1 standard deviation *above* the mean. This same percentage (34.13%) of scores lies between the mean and 1 standard deviation *below* the mean. Approximately two-thirds of the scores lie within 1 standard deviation of the mean (68.26%), and approximately 95% of the scores lie within 2 standard deviations of the mean. Finally, over 99% of the scores fall within 3 standard deviations of the mean. Thus scores that fall more than 2 standard deviations from the mean are relatively rare (sometime identified as being "clinically significant").

Standard Deviation

The standard deviation is a measure of the variability of a distribution of test scores. Test developers need to know the standard deviation of the distribution of a tests raw scores before they can standardize these raw scores. Tests that have very little variability (the raw scores are very similar to each other) have small standard deviations, while tests that have significant variability (the raw scores obtained by individuals taking the test are very different from each other) have large standard deviations. The standard deviation of a distribution of raw scores is the square root of the variance. The variance is the sum of the squared raw score values (ΣX^2) minus the square of the sum of all the raw scores $(\Sigma X)^2$ divided by the number of raw scores (N). The resulting figure is then divided by the number of raw scores minus 1 ($N - 1$). This formula is summarized in the following figure:

$$\sqrt{\frac{\Sigma X^2 - \frac{(\Sigma X)^2}{N}}{N - 1}}$$

Standard Scores

When a set of raw scores is converted to standard scores the scores are said to be "standardized." The purpose of standard scores (e.g., *Z*-scores, IQ Scores, *T*-scores, scaled scores) is to transform individual raw scores into a standard form that provides a more meaningful description of the individual scores within the distribution. Raw test data is rarely valuable to the school psychologist. For example, a raw score of 5 on the *Wechsler Intelligence Scale for Children* (WISC) Information subtest may mean different things for different students. A raw score of 5 for a six-year-old will be suggestive of a different level of cognitive functioning than will the same score for a seven-year-old. In addition, a raw score of 5 on one test will not have the same meaning as a raw score of 5 on another test. Thus, the raw scores obtained via psychological tests are most commonly interpreted by reference to norms and by their conversion into some relative reference or "standard" score (a descriptive statistic).

Norms represent the test performance of individuals within a standardization sample. For example, they document how well the standardization sample's six-year-olds did on the *WISC* Information subtest. *Derived scores* are the descriptive statistics used to transform raw test data into a number that more precisely illustrates a student's exact position relative to individuals in the normative group. For example, at age six, a raw score of 5 on the *WISC* Information subtest corresponds to a scaled score of 10. While at age seven, this same raw score corresponds to a scaled score of 6. Derived scores also provide comparable measures that allow direct comparison of a student's performance on different tests. Thus, allowing the school psychologist to identify a relative pattern of unique strengths and weaknesses. For example, a scaled score of 10 on the Information subtest (RS = 5) can be directly compared to a scaled score of 3 on the Coding subtest (RS = 5). Understanding the conversion of raw scores into standard scores, and how they are used to describe a student's performance relative to others (as well as their own unique pattern of strengths and weaknesses) requires knowledge of basic statistical concepts. These concepts underlie the development and utilization of norms. It is critical that school psychologists, who use psychological tests, have a solid understanding of these descriptive statistics.

***Z*-Scores**

Z-Scores are a transformation of individual raw scores into a standard form, where the transformation is based on knowledge about the standardization sample's mean and standard deviation. The formula for computing *Z*-scores is the individual raw score (X) minus the mean of the scores obtained by the standardization sample (M), divided by the standard deviation of scores obtained by the standardization sample (*sd*). *Z*-scores have a mean of 0 and a standard deviation of 1. A score that is one standard deviation below the mean has a Z-score of -1. A score that is at the mean would have a Z-score of 0. The formula for transforming a raw score into a *Z*-score is a follows:

$$\frac{X - M}{sd} = Z$$

Because of the fact that the pulse (+) and minus (-) signs can easily get lost when looking at this type of standard score, *Z*-scores are frequently converted into other types of standard scores. Specifically they are often transformed into Deviation IQ scores, T-scores, and scaled scores.

Deviation IQ Scores

Deviation IQ Scores are a standard score with a mean of 100 and a standard deviation of 15. *Z*-scores can be transformed into Deviations IQ scores by multiplying the given *Z*-score by 15 (the standard deviation of the distribution of Deviation IQ scores), and adding 100 (the mean of the distribution of Deviation IQ scores) to this product. For example, a *Z*-score of –1 equals a Deviation IQ of 85 [100 + 15(-1) = 85]. The formula for transforming a *Z*-score into a Deviation IQ score is a follows:

$$100 + 15(z)$$

If the skills measured by an IQ test are normally distributed, we would expect that two-thirds (68.26%) of the population would have deviation IQ's between 85 and 115. This is considered the normal range. Further, we would expect that 95% of the distribution lies within 2 standard deviations of the mean (that is IQs between 70 and 130). Thus, scores that fall above 130 and below 70 would be considered unusually high and unusually low, as only 5% of the population obtains higher or lower scores.

T-Scores

T-scores are standard scores with a mean of 50 and a standard deviation of 10. *Z*-scores can be transformed into T-scores scores by multiplying the given *Z*-score by 10 (the standard deviation of the distribution of T-scores), and adding 50 (the mean of the distribution of T-scores) to this product. For example, a *Z*-score of –1 equals a Deviation IQ of 40 [50 + 10(-1) = 40]. The formula for transforming *Z*-score into a T-score is a follows:

$$50 + 10(z)$$

If the variable measured by a psychological test is normally distributed, we would expect that two-thirds (68.26%) of the population would obtain scores between 40 and 60. This is considered the normal range. Further, we would expect that 95% of the distribution lies within 2 standard deviations of the mean (that is T-scores between 30 and 70). Thus, scores that fall above 70 or below 30 would be considered unusually high and unusually low, as only 5% of the population obtains higher or lower scores.

Scaled Scores

Scaled scores are standard scores with a mean of 10 and a standard deviation of 3. *Z*-scores can be transformed into scaled scores by multiplying the given *Z*-score by 3 (the standard deviation of the distribution of scaled scores), and adding 10 (the mean of the distribution of scaled scores) to this product.

For example, a *Z*-score of –1 equals a scaled of 7 [10 + 3(-1) = 7]. The formula for transforming *Z*-score into a scaled score is a follows:

$$10 + 3(z)$$

If the variable measured by a psychological test is normally distributed, we would expect that two-thirds (68.26%) of the population would obtain scores between 7 and 12. This is considered the normal range. Further, we would expect that 95% of the distribution lies within 2 standard deviations of the mean (that is scaled scores between 4 and 16). Thus, scores that fall above 16 or below 4 would be considered unusually high and unusually low, as only 5% of the population obtains higher or lower scores. As was mentioned earlier, the term "clinically significant" is sometimes used to describe these unusually high or low scores.

Percentile Ranks

The percentile rank reflects the percentage of scores that are lower than an obtained test score. For example, a test result that fell at the 75th percentile rank is higher than that obtained by 74% of the population. In other words, the individual obtaining this test score scored higher than 74% of the individuals in the standardization group.

The median for any set of raw scores is the 50th percentile. That is, 50% of the scores are lower than the median, and 50% of the scores are higher than the median. Typically percentiles are reported as whole numbers so the highest percentile possible would be 99 and the lowest possible would be 1[2].

Another way to think about percentile ranks is that they reflect the percentage of the area underneath the normal curve that is to the left of the given score. For example, a score that is 2 standard deviations below the mean would have a percentile rank of 2 (0.13 + 2.14 = 2.27). In other words, just over 2% of the area underneath the normal curve is to the left of a standard score that is 2 standard deviations below the mean. On the other hand a score that is 2 standard deviations above the mean would have a percentile rank of 98 (0.13 + 2.14 +13.59 + 34.13 + 34.13 + 13.59 = 97.71). In other words, just under 98% of the area underneath the normal curve is to the left of a standard scores that is 2 standard deviations above the mean. The following table illustrates the relationship between specific percentile scores and specific *Z*-scores, Deviation IQ scores, T-scores, and scaled scores.

[2] Some test designers have used the concept of extended percentile ranks to make finer divisions for scores at the upper half of the 99th percentile and at the lower half of the 1st percentile (e.g., they may report a given score as falling at the 99.7 percentile rank).

Percentile Rank	*Z-Score*	*Deviation IQ (SD = 15)*	*T-Score*	*Scaled Score*
99	+2.33	135	73	17
98	+2.05	131	71	16
97	+1.88	128	69	
96	+1.75	126	68	
95	+1.64	125	67	15
94	+1.55	123	66	
93	+1.48	122	65	
92	+1.41	121	64	
91	+1.34	120		14
90	+1.28	119	63	
89	+1.22			
88	+1.18	118	62	
87	+1.13	117		
86	+1.08	116	61	
85	+1.04			
84	+0.99	115	60	13
83	+0.95			
82	+0.91	114	59	
81	+0.88	113		
80	+0.84			
79	+0.80	112	58	
78	+0.77			
77	+0.74	111		
76	+0.71		57	
75	+0.67	110		12
74	+0.64			
73	+0.61	109	56	
72	+0.58			
71	+0.55			
70	+0.52	108		
69	+0.49		55	
68	+0.47	107		
67	+0.44			
66	+0.41	106	54	
65	+0.39			
64	+0.36			
63	+0.33	105		11
62	+0.31		53	
61	+0.28	104		
60	+0.25			
59	+0.23			
58	+0.20	103	52	
57	+0.18			
56	+0.15			
55	+0.12	102		
54	+0.10		51	
53	+0.07	101		

52	+0.05			
51	+0.03			
50	0.00	100	50	10

Percentile Rank	*Z Score*	*Deviation IQ (SD = 15)*	*T-Score*	*Scaled Score*
50	0.00	100	50	10
49	-0.03			
48	-0.05			
47	-0.07	99		
46	-0.10		49	
45	-0.12	98		
44	-0.15			
43	-0.18			
42	-0.20	97	48	
41	-0.23			
40	-0.25			
39	-0.28	96		
38	-0.31		47	
37	-0.33	95		9
36	-0.36			
35	-0.39			
34	-0.41	94	46	
33	-0.44			
32	-0.47	93		
31	-0.49		45	
30	-0.52	92		
29	-0.55			
28	-0.58			
27	-0.61	91	44	
26	-0.64			
25	-0.67	90		8
24	-0.71		43	
23	-0.74	89		
22	-0.77			
21	-0.80	88	42	
20	-0.94			
19	-0.88	87		
18	-0.91	86	41	
17	-0.95			
16	-0-99	85	40	7
15	-1.04			
14	-1.08	84	39	
13	-1.13	83		
12	-1.18	82	38	
11	-1.22	82		
10	-1.28	81	37	
9	-1.34	80		6
8	-1.41	79	36	
7	-1.48	78	35	
6	-1.55	77	34	
5	-1.64	75	34	5
4	-1.75	74	33	

3	-1.88	72	31	
2	-2.05	69	30	4
1	-2.33	65	27	3

NAME:	A D	SCHOOL:	HOME SCHOOL.
BIRTH DATE:	12/17/93	GRADE:	5
ASSESSMENT DATE:	09/07/2005		
AGE:	11-1	TEACHER:	PARENTS
PRIMARY LANGUAGE:	ENGLISH	EXAMINER:	DAVE HUNTER

PLAIN LANGUAGE PSYCHO-EDUCATIONAL REPORT SUMMARY

A is of average intelligence. Socially and emotionally there are no areas of apparent concern. Her occasional inattentiveness is most likely due to the academic difficulty she is having.

A is good at remembering, thinking about and/or reproducing pictures presented visually which could help if applied to learning and is a special talent which could be developed.

A has trouble recalling information sometimes. She is better at recalling pictures than words.

A has several weaknesses that make it more difficult for her to read and understand what she has read including:

- She sometimes recalls information slowly when she has to respond with words.
- She has trouble distinguishes the sounds of the words she hears and it makes it difficult for her to recognize the words she sees on a page.
- She has trouble holding information in her head while she processes or "thinks about" it.

A will benefit from extra reading help, one-on-one or in a small group, particularly with a reading program that is designed for children with reading difficulty. Such programs move slower and teach letter sounds more directly, in a very specific order and with greater opportunity for repetition.

She would also benefit from repeatedly reading passages that are easy for her so she can increase her confidence and reading speed.

Our goal is to get A to the point where she will choose to read for enjoyment from books that are easy for her. I am optimistic that this is possible for her soon.

Analysis of Data

Although A has Average overall intelligence as evidenced by her General Conceptual Ability Score of 96 on the DAS, she has at least three areas of relative weakness that are likely to be contributing to her overall poor reading and academic skills.

A has an uneven, but relative weakness in her processing speed as reflected in her Low scores on the Speed of Information Processing subtest of the DAS, her low Rapid Naming score on the CTOPP, and her low scores on the Reading Fluency and Math Fluency academic tests. Slow processing is particularly associated with reading and reading comprehension difficulty.

A has poor Phonemic Awareness skills which make it difficult for her to sound out unfamiliar words. This is evidenced by her very low scores on the Phonemic Awareness subtests of the CTOPP and is an emblematic pattern for children with reading difficulty. Low scores on the Phonemic Awareness subtests primarily evidence a weakness in her ability to process the sounds of language rather than a lack of instruction in this area.

Also, A scored low on the Long Term Retrieval subtest of the WJ-III, particularly the subtest which informs of her ability to learn new visual information by sight. This is consistent with her Low Word Definitions score on the DAS and her inability to recall spelling words after a short period of time, as reported by her mother. This impacts reading because it inhibits her ability to recognize sight words.

In combination, poor processing speed, poor word recognition and poor skills in sounding out new words are contributing to slow reading speed. Poor phonemic awareness and the resulting poor reading fluency is a major factor in poor reading comprehension and may be dissuading A from reading for enjoyment. A reports that she does not enjoy reading and this may be limiting her exposure to print and contributing to her low vocabulary and language skills. Poor memory and language abilities may also be causing A's writing difficulty.

A's Low Math Fluency and poor processing speed are also associated with the poor math performance reported by her mother. A's difficulty in Long Term Retrieval would also make it hard for A to remember important math facts and procedures. And, Name's apparent difficulty with working memory makes it difficult to do math processes while simultaneously remembering necessary information

It is difficult to isolate any attention difficulties observed by Mrs. D from academic frustration that A may be experiencing. Given that the attention difficulties are not prominent, it may not be useful to specify the impact of the observed difficulty.

Finally, it is difficult to determine if any of A's weaknesses in academic areas could be the result of non-standard instruction, limited instruction or instruction not suited to her unique needs.

Summary and Recommendations

- The D's might consider providing more instruction to A; particularly remedial reading instruction. Up to two hours of specific reading instruction per school day are recommended. Also, A might benefit from one hour of reading instruction each day over the summer to help her catch up and provide continuity to compensate for her memory weaknesses. Pleasure reading on the weekends should be encouraged.

- If A were enrolled in public school, she would probably qualify for special education services. To fulfill the extra reading requirement for A, the D's might consider accessing the RSP classroom at their local public school, extending the hours of in-home tutoring by her current tutor or providing the instruction themselves either directly or facilitated through computer and/or peer-assisted methods.

- If the D's decide to provide the instruction to A directly, they might benefit from accessing information specific to teaching children with reading difficulty such as "What Research Tells us about Children with Diverse Learning Needs" by Deborah Simmons and Edward J Kameenui or "Overcoming Dyslexia" by Sally Shaywitz. Also, the D's might find valuable information on the website for learning disabilities at: www.**ldonline**.org/.

- The D's might also consider revising A's curriculum, in whole or in part, to include more systematic, intensive learning materials that are appropriate for students with learning difficulty. An example of such a program would be the Funnix reading program which is accessible to home schooled learners at http://www.funnix.com/. (approximately $200) The resource program teacher at the local public school might also have suggestions. A's relative strength in visual spatial processing and her overall good performance in recalling visual stimuli suggest that she would benefit from visual learning materials such as computer instruction materials or other graphic learning aids..

- In addition to the "Victory Drill" that A does for reading fluency, she might benefit from repeated readings of relatively easy connected text passages.

- A would benefit from reading for pleasure, but in order to encourage this it is important to find appropriate reading materials. It would help to provide her with materials that she can read with ease in order to build confidence and enjoyment. It might help to find materials that are compatible with her interests in science and animals. Appropriate books for pleasure reading are those that A can read with 90% accuracy.

- A might also benefit from increasing her computer literacy. Over time, programs like Kidspiration http://www.inspiration.com/home.cfm and even simple resources like spell check, word prediction software or online dictionaries and thesauruses may support her. Typing can be integrated with reading instruction through the program ReadWriteandType! at http://www.readwritetype.com/ ($79).

- Build on A's visual strengths by continuing to foster her artistic talents.

Thank you for the opportunity to work with A. She was enjoyable and easy to be with and we wish your whole family the best with both academic and life pursuits.

_____
Dave Hunter
School Psychology Graduate Student

_____
Dorothy Marshall, Ph.D.
Supervising School Psychologist

Cognitive Assessments – Pre School to School Age

NAME	ACRONYM	AGE / GRADE Range
Bateria	--	2:0-90:0+
Das-Naglieri Cognitive Assessment System	CAS	5:0-17:0
Differential Ability Scales -2nd Ed.	DAS-2	2:6-5:11
Kaufman Assessment Battery for Children -2nd Ed.	KABC-2	3:0-6:0
Kaufman Brief Intelligence Test -2nd Ed.	KBIT-2	4:0-90:0
Leiter International Performance Scale - Revised	Leiter-R	2:0-20:0
Mullen Scales of Early Learning	--	Birth-5:8
Naglieri Nonverbal Ability Test -2nd Ed.	NNAT	4:0-18:0
A Developmental Neuropsychological Assessment 2nd Ed.	NEPSY-2	3:0-4:0, 5:0-16:0
Primary Test of Nonverbal Intelligence	PTONI	3:0-9:0
Stanford-Binet Intelligence Scales -5th Ed	SB5	2:0-85:0+
Universal Nonverbal Intelligence Test	UNIT	5:0-17:0
Wechsler Nonverbal Scale of Ability	WNV	4:0-21:11
Wechsler Preschool and Primary Scale of Intelligence -3rd Ed.	WPPSI-III	2:6-7:3
Woodcock Johnson Tests of Cognitive Abilities -3rd Ed.	WJ-III	2:0-90:0+
Woodcock-Johnson Diagnostic Supplement	--	2:0-90:0

Cognitive Assessments – School Age to 17 (or adult)

NAME	ACRONYM	AGE / GRADE Range
Bateria	--	2:0-90:0+
Comprehensive Test of Nonverbal Intelligence -2nd Ed.	CTONI-2	6:0-89:11
Das-Naglieri Cognitive Assessment System	CAS	5:0-7:0
Differential Ability Scales -2nd Ed.	DAS-2	2:6-5:11
Kaufman Assessment Battery for Children -2nd Ed.	KABC-2	3:0-6:0
Kaufman Brief Intelligence Test -2nd Ed.	KBIT-2	4:0-90:0
Leiter International Performance Scale - Revised	Leiter-R	2:0-20:0
Mullen Scales of Early Learning	--	Birth-5:8
Naglieri Nonverbal Ability Test -2nd Ed.	NNAT	4:0-18:0
A Developmental Neuropsychological Assessment 2nd Ed.	NEPSY-2	3:0-4:0, 5:0-16:0
Stanford-Binet Intelligence Scales -5th Ed	SB5	2:0-85:0+
Test of Nonverbal Intelligence -3rd Ed. (Form A&B)	TONI-3	6:0-89:0+
Universal Nonverbal Intelligence Test	UNIT	5:0-17:0
Wechsler Adult Intelligence Scale -3rd Edition	WAIS-3	16:0-89:0
Wechsler Intelligence Scale for Children -4th Ed.	WISC-4	6:0-16:11
Wechsler Intelligence Scale for Children, -4th Ed *Integrated*	WISC-4 *Integrated*	6:0-16:11
Wechsler Nonverbal Scale of Ability	WNV	4:0-21:11
Wechsler Preschool and Primary Scale of Intelligence -3rd Ed.	WPPSI-III	2:6-7:3
Woodcock Johnson Tests of Cognitive Abilities -3rd Ed.	WJ-III	2:0-90:0+
Woodcock-Johnson Diagnostic Supplement	--	2:0-90:0

Process Specific

NAME	ACRONYM	AGE / GRADE Range

Developmental Test of Visual Perception -2nd Ed.	DTVP-2	4:0-10:0
Expressive Vocabulary Test -2nd Ed. (Form A)	EVT-2	2:6-90:0+
Motor Free Visual Perception Test -3rd Ed.	MVPT-3	4:0-85:0
Process Assessment of the Learner -2nd Ed. (Reading/Writing)	PAL-2	Grades K-6
Process Assessment of the Learner -2nd Ed. (Math)	PAL-2	Grades K-6
Test of Auditory Processing Skills -3rd Edition	TAPS-3	4:0-18:11
Test of Everyday Attention for Children	TEA-CH	6:0-16:0
Test of Memory and Learning -2nd Ed.	TOMAL-2	5:0-59:0
Wide Range Assessment of Memory and Learning -2nd Edition	WRAML-2	5:0-90:0:0

Adaptive Behavior

NAME	ACRONYM	AGE / GRADE Range
Adaptive Behavior Assessment System -2nd Ed.	ABAS-2	5:0-21:0
Adaptive Behavior Scale—School -2nd Ed.	ABS-S:2	3:0-21:0
Vineland Adaptive Behavior Scale	--	Birth-18:11

Social-Emotional/Behavioral/Clinical

NAME	ACRONYM	AGE / GRADE Range
ADHD Symptoms Rating Scale	ADHD-SRS	5:0-18:0
Attention/Deficit -Hyperactivity Disorder Test	ADHD-T	3:0-23:0
Asperger Syndrome Disorder Scale	ASDS	5:0-18:0
BarOn Emotional Quotient-Inventory	BarOn EQ-i	7:0+
Beck Depression Inventory -2nd Ed.	BDI-2	13:0-80:0
Beck Youth Inventories -2nd Ed.	BYI-2	7:0-18:0
Behavior Assessment System for Children -2nd Ed.	BASC-2	Parent/Teacher: Ages 2:0-21:0 Self-report: Ages 8:0-25:0
Behavioral and Emotional Rating Scales	BERS	Parent/Teacher/ Youth: Ages 5:0-18:11
Brown Attention Deficit Disorder Scales	Brown ADD Scales	Parent/Teacher/ Self-report: Ages 3:0-18:0
Child Behavior Checklist; parent/teacher	CBCL or Achenbach	Parent/Teacher: Ages 6:0-18:0, Youth: Ages 11:0-18:0
Childhood Autism Rating Scale	CARS	2:0+
Child Depression Inventory-2	CDI	7-17
Coddington Life Events Scales	CLES	5:0-19:0
Conduct Disorder Scale	CDS	5:0-22:0
Conners -3rd Ed.	Conners-3	6:0-18:0

Culture Free Self Esteem Inventory -3rd Ed.	CFSEI-3	6:0-18:11
Differential Test of Conduct-Emotional Problems	DT/CEP	Grades K-12
Emotional Disturbance Decision Tree	EDDT	5:0-18:0
Gilliam Autism Rating Scale -2nd Ed.	GARS-2	3:0-22:0
Guess Why Game	--	--
Multidimensional Anxiety Scale for Children	MASC	8:0-19:0
Reynolds Adolescent Depressive Scale -2nd Ed.	RADS-2	11:0-20:0
Revised Children Manifest Anxiety Scale -2nd Ed.	RCMAS-2	6:0-19:0
Roberts Apperception Test for Children and Adolescents - 2nd Ed.	Roberts-2	6:0-18:0
Scale for Assessing Emotional Disturbance	SAED	5:0-18:0
Sentence Completions	--	--
Forer Structured Sentence Completion Test	--	--
Rotter Incomplete Sentences Blank (RISB), High School Response Sheet	RISB	--
Social Skills Rating System	SSRS	Parent/Teacher: Grades Preschool - 12 Student: Grades 3-12
Tell Me A Story	TEMAS	5:0-13:0

Overall Academic Achievement

NAME	ACRONYM	AGE / GRADE Range
Diagnostic Achievement Battery -2nd Ed.	DAB-2	6:0-14:11
Kaufman Test of Educational Achievement -2nd Ed. (Form A&B)	KTEA-2	4:6-25:0
Wechsler Individual Achievement Test -3rd Ed.	WIAT-3	4:0-85:0
Wide Range Achievement Test -4th Ed.	WRAT-4	5:0-94:0
Woodcock Johnson Tests of Achievement -3rd Edition (Form A)	WJ-3 ACH	2:0-90:0+

Reading/Language

NAME	ACRONYM	AGE / GRADE Range
Comprehensive Assessment of Spoken Language	CASL	3:0-21:0
Comprehensive Test of Phonological Processing -2nd Ed.	CTOPP-2	4:0-24:11
Dynamic Indicators of Basic Early Literary Skills -6th Ed. (Grades 1-3)	DIBELS	Grades 1-3
Grey Oral Reading Test -5th Ed.	GORT-5	6:0 – 23:11
Peabody Picture Vocabulary Test -4th Ed.	PPVT-4	2:6-90:0+
Process Assessment of the Learner -2nd Ed. (Reading/Writing)	PAL-2	Grades K-6
Rapid Automatized Naming & Rapid Alternating Stimulus Test	RAN/RAS	5:0-18:0
Test of Word Reading Efficiency -2nd Ed.	TOWRE-2	6:0-24:0
Test of Silent Word Reading Fluency	TOSWRF	6:6-17:11
Woodcock Diagnostic Reading Battery	WDRB	4:0-95:0

Math

NAME	ACRONYM	AGE / GRADE Range
Comprehensive Mathematical Abilities Test	CMAT	7:0-18:0
Key Math -3rd Ed. (Form A&B)	--	4:6-21:0
Process Assessment of the Learner -2nd Ed. (Math)	PAL-2	Grades K-6

Written Language

NAME	ACRONYM	AGE / GRADE Range
Oral & Written Language Scales	OWLS	3:0 or 5:0- 21:0
Test of Written Language -3rd Edition	TOWL-4	9:0-17:11
Test of Written Spelling -4th Edition	TWS-4	6:0-18:11

Interventions

NAME	ACRONYM	AGE / GRADE Range
Academic Competence Evaluation Scales	ACES	Teacher: Grades K-12 Student: Grades 6-12
Academic Intervention Monitoring System	AIMS	Parent/Teacher: Grades K-12 Student: Grades 6-12
Functional Assessment and Intervention System: Improving School Behavior, early childhood through high school	FAIS	--
Process Assessment of the Learner -2nd Edition (Reading/Writing)	PAL-2	Grades K-6
Process Assessment of the Learner -2nd Edition (Math)	PAL-2	Grades K-6

Additional Tests

NAME	ACRONYM	AGE / GRADE Range
Bracken Basic Concept Scale -Revised	BBCS-R	2:6-8:0
Bilingual Verbal Ability Tests	BVAT	5:0+
Kaufman Survey of Early Academic & Language Skills	K-SEALS	3:0-6:11
Motivation Assessment Scale	--	--
Portable Tactile Performance Test	--	--
Wechsler Fundamentals: Academic Skills	--	Ages 18:0-50:0 Grades K-12

THE "GETTING TO KNOW YOU" WORKSHEET

Name: _____ Date: _____
Age: _____ Grade: _____ AKA: _____

1. Favorite Activity/Hobby?

2. Favorite Subject in School?

3. Least favorite subject in school?

4. Favorite song/music?

5. Favorite movie?

6. Favorite television show?

7. Favorite sport and/or team?

8. Favorite food?

9. Favorite color?

10. Favorite animal?

GUESS WHY GAME

NAME: _____ DATE: _____

Directions: *"I know a boy (girl) named Robert (Mary) and I want to see if you can guess what kind of boy (girl) he (she) is and why he (she) acts the way he (she) does. Tell me the first thing that you think of. For example:"*

Question	Response
…doesn't play with the other boys (girls). Why?	
…'s teacher asked him (her) to see her after school. Why?	
When …'s father came home last night, what happened?	
… woke up in the middle of the night. Why?	
…had a dream one night. What was it about?	
…brought home his report card yesterday. What happened?	
…'s mother put on her coat and left the house. Why?	
…came home crying the other day. Why?	
…felt mad at his (her) mother one day. Why?	
…went to his (her) room. Why?	
…'s feelings are hurt at times. Why?	
…'s mother was very upset about something. Why?	
…did not come home for supper. Why?	
Yesterday something went wrong. What was it?	
There is something that … doesn't like about his father. What is it?	

…thinks his (her) mother and father don't like him. Why?	
… did not want to go to school today. Why?	
…especially likes one thing about his teacher. Why?	
Sometimes … gets angry in school. Why?	
Sometimes … doesn't do what his (her) mother tells him to do. Why? What happens?	
…wishes he (she) were grown up. Why?	
Sometimes …fights with his(her) brother. Why? What happens?	
…doesn't like a certain person in school. Why?	
Sometimes …gets nervous and upset in school. Why?	
One day …and his (her) mother had a big argument. Why?	
One day …left the house. Why?	
…dislikes something about his (her) teacher. Why?	
Sometimes …feels very sad. Why?	
…usually likes to be by him (her) self. Why?	
…once wanted to run away from home. Why?	
…doesn't like to be called on in class. Why?	
How old do you think …is?	

If …could do anything he (she) wanted, what would he (she) do that he (she) can't do now?	
What does …wish for most of all?	

SENTENCE COMPLETION 1

Name: _____ Date: _____

Prompt	Response
I like:	
The happiest time is:	
When I am older I will:	
What bothers me is:	
If I could spend one week alone with anybody I chose, it would be:	
I sometimes worry about:	
In school, my teachers:	
It is easy for me to:	
Mothers are:	
I look forward to:	
Most girls (boys):	
My family treats me like:	
When I was younger I:	

I am sometimes afraid of:	
If only my father would:	

The thing I like best about school is:	
It makes me angry when:	
Most of my friends don't know that I:	
I am generally:	
My mother and I:	
It is hard for me to:	
Compared to most families, mine is:	
I never want to:	
The thing I can do best is:	
One of my happiest memories is:	
If I discovered a magic genie and was told I could have 3 wishes, I would ask for:	1. 2. 3.
Chores I have to do are:	
Pets we have:	
Things my family does together:	
The thing I like best about my family is:	

One thing I would like to change is:	

SENTENCE COMPLETION 2

Name: _____ Date: _____

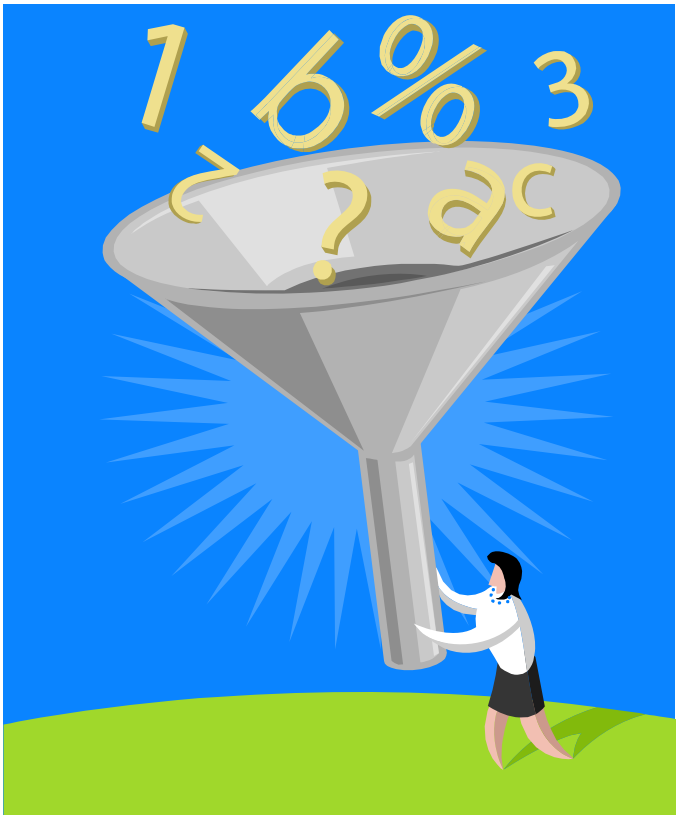
Prompt	Response
When I grow up I'd like to:	
I dream about:	
I am very happy when:	
I want to be like:	
My mother thinks I am:	
My teacher thinks I am:	
My teacher wants me to:	
Brothers and sisters:	
A person must never:	
When the teacher says:	
I wish:	

I can't:	
Most people are:	
I cannot understand what makes me:	
I think I am:	
I get angry when:	
My greatest fault is:	
The trouble with some families:	
I used to be afraid:	
But now the thing that frightens me the most is:	
Mother:	
Because of Mom:	
If I could only:	
When I think:	
I hope:	

I like to:	
I expect my friends:	
When I do something right:	
My father wants me to:	
I want to:	

Notes:

DATA ANALYSIS



DATA ANALYSIS TEMPLATE

Reason for Referral

Identification of Assets and Challenges

Learning Assets	Data Sources	Etiological Considerations[1]
1.	a.	**Fx**:
	b.	**Dx**:
	c.	**Ex**:
	d.	**Hx**:
2.	a.	**Fx**:
	b.	**Dx**:
	c.	**Ex**:
	d.	**Hx**:
3.	a.	**Fx**:
	b.	**Dx**:
	c.	**Ex**:
	d.	**Hx**:
Learning Challenges	Data Sources	Etiological Considerations[1]
1.	a.	**Fx**:
	b.	**Dx**:
	c.	**Ex**:
	d.	**Hx**:
2.	a.	**Fx**:
	b.	**Dx**:
	c.	**Ex**:
	d.	**Hx**:
3.	a.	**Fx**:
	b.	**Dx**:
	c.	**Ex**:
	d.	**Hx**:

[1] Fx = family history (e.g., ADHD, SLD); Dx = developmental history (e.g., milestones); Ex = environmental history (e.g., stressors); Hx = health history (e.g., chronic ear infections).

The Effects of Assets and Challenges and Associated Recommendations

Learning Assets	Effects	Data Sources	Recommendations
1.	a.	a.	
	b.	b.	
	c.	c.	
	d.	d.	
2.	a.	a.	
	b.	b.	
	c.	c.	
	d.	d.	
3.	a.	a.	
	b.	b.	
	c.	c.	
	d.	d.	
Learning Challenges	Effects	Data Sources	Recommendations
1.	a.	a.	
	b.	b.	
	c.	c.	
	d.	d.	
2.	a.	a.	
	b.	b.	
	c.	c.	
	d.	d.	
3.	a.	a.	
	b.	b.	
	c.	c.	
	d.	d.	

Hypothesis Generation Worksheet

Concern	Possible Explanation (hypothesis) (each concern may have more than one possible explanation)	Evidence for explanation	Evidence against explanation

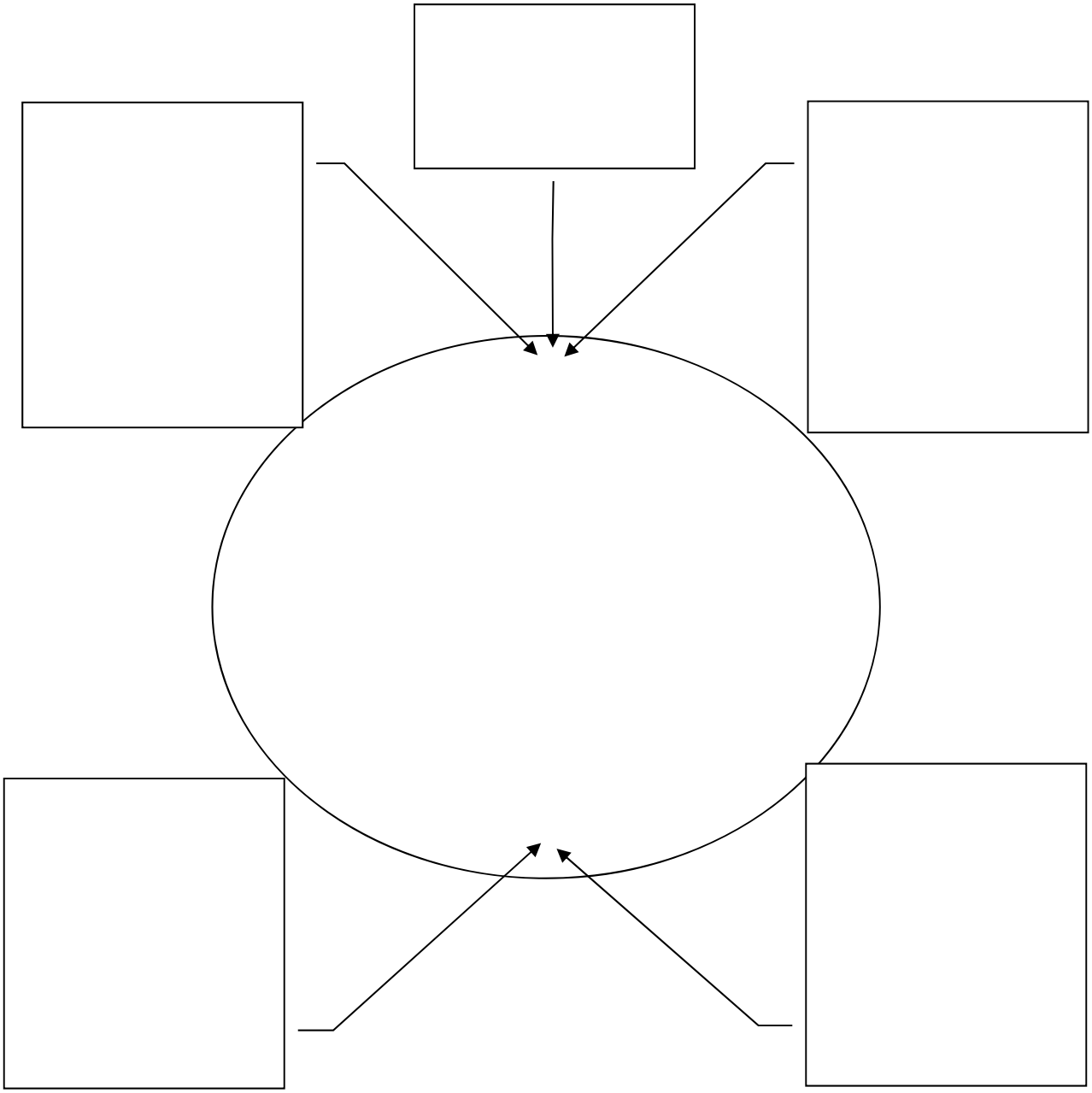
HYPOTHESIS ILLUSTRATION WORKSHEET

Write in the circle, the primary challenge faced by the student

Write in the boxes, factors that are judged to influence the learning challenge (connect boxes as indicated)

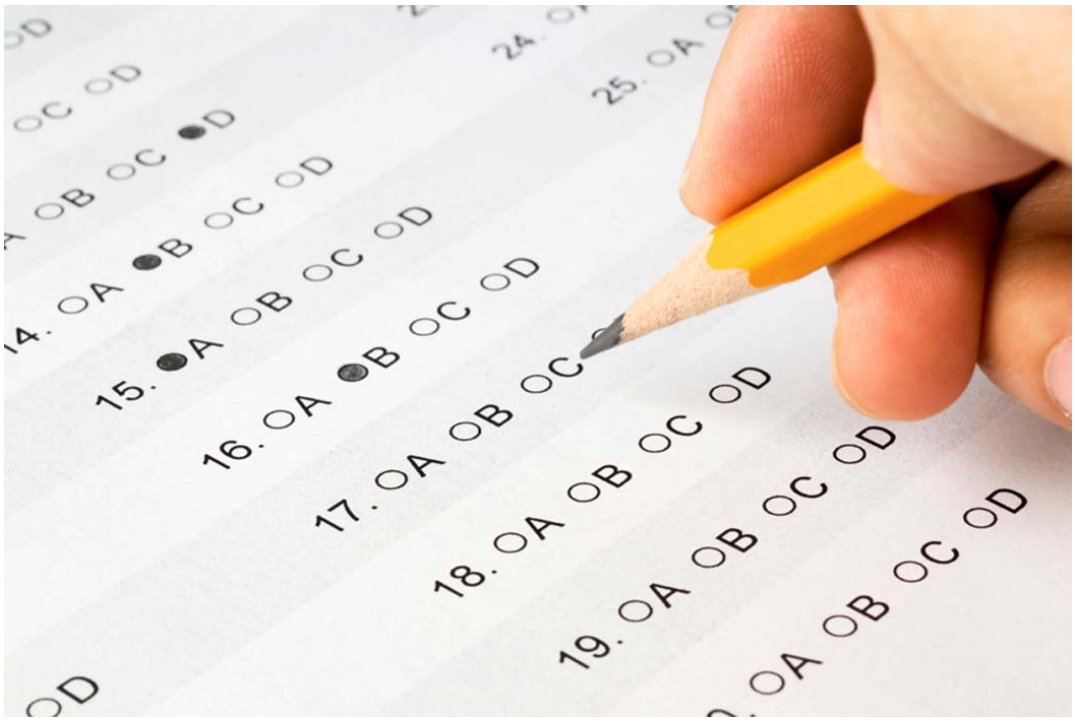
Write in boxes at the bottom of the page questions yet to be answered and referring concerns that have been ruled out

If necessary, use a separate worksheet for each of the student's learning challenges



Questions that still exist	Referring concerns that have been ruled out

REQUIREMENTS FOR COLLEGE BOARDS AND EXTENDED TIME


15. ●A ○B ○C ○D
16. ○A ●B ○C ○D
17. ○A ○B ○C
18. ○A ○B ○C ○D
19. ○A ○B ○C ○D

From http://professionals.collegeboard.com/testing/ssd/accommodations/time

Documentation guidelines for extended time

Please keep in mind that a student's documentation must demonstrate not only that he or she has a disability, but also that the student **requires** the accommodation being requested. Therefore, a student who requests extended time should have documentation that demonstrates difficulty taking tests under timed conditions. In most cases, the documentation should include scores from **both timed and extended/untimed tests**, to demonstrate any differences caused by the timed conditions.

The following tests are commonly used to measure a student's academic skills in timed settings. Because tests are frequently developed and updated, this list is not exhaustive. There are other timed tests that may also be used. Tests must be conducted under standardized procedures.

- **Nelson Denny Reading Test, with standard time and extended time measures Stanford Diagnostic Reading Test (SDRT)**
- **Stanford Diagnostic Math Test (SDMT)**
- **Woodcock-Johnson III Fluency Measures**
- **Test of Written Language-Third Edition (TOWL-3)**

When these tests are administered under standardized conditions, and when the results are interpreted within the context of other diagnostic information, they provide useful diagnostic information about testing accommodations. A low processing speed score alone, however, usually does not indicate the need for testing accommodations. In this instance, it would be important to include documentation to support how the depressed processing speed affects the student's overall academic abilities under timed conditions.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER DIAGNOSTIC EVALUATION: HEALTH, FAMILY, DEVELOPMENTAL, & BEHAVIORAL HISTORY INTERVIEW FORM

Child's Name: _____ Birth date: _____
School: _____ Grade: _____
Parent(s): _____ E-mail: _____
Home phone: _____ Alt. Phone: _____
Languages spoken in the home: _____
Siblings and their ages: _____
Other adults living in the home: _____

Referring concern: _____
_____
_____
_____
_____
_____

At what age did the referring concerns first emerge? _____

HEALTH HISTORY (PERINATAL FACTORS)

1. General obstetric status (circle one): Optimal Adequate Poor

2. Complications during pregnancy (circle all that apply): Eclampsia, Diabetes mellitus, Placenta previa, Multiple pregnancies, Abnormal fetal position
   Other (list): _____
   _____
   _____

3. Was there threatened miscarriage (circle)? YES NO If YES describe below:
   _____
   _____
   _____

4. Maternal illnesses during the pregnancy (list when illness occurred):
   _____
   _____
   _____

HEALTH HISTORY (PERINATAL FACTORS; CONTINUED)

5. Mothers age time of the pregnancy (list): _____

6. Alcohol exposure during pregnancy (circle): YES NO If YES answer the following:
   a. How often did mother drink? Every day Once a week Rarely
   b. How much did mother drink? Just a little One drink Several drinks
   c. When during pregnancy did the mother drink? 1st trimester 2nd Trimester 3rd trimester

7. Cigarette exposure during pregnancy (circle): YES NO If YES answer the following:
   a. How often did mother smoke? Every day Once a week Rarely Never
   b. How much did mother smoke? Just a little One cigarette Several cigarettes
   c. When during pregnancy did the mother smoke? 1st trimester 2nd Trimester 3rd trimester

8. Medication/Drug exposure during pregnancy (circle): YES NO If YES answer the following:
   What drugs were taken? (list): _____
   _____
   _____
   _____
   a. When during pregnancy were medications/drugs taken? 1st trimester 2nd Trimester 3rd trimester

9. Birth weight (list): _____lbs. _____oz.
   (if exact weight not known check one of the following)
   _____less than 2.2 lbs. _____less than 5.5 lbs.
   _____less than 3.3 lbs. _____more than 5.5 lbs.

10. Length (list): _____inches

11. Length of pregnancy (circle/list): Full term Premature @ _____weeks

12. Was and incubator required (circle): YES NO If YES report how long: _____

13. Was oxygen therapy required (circle): YES NO

14. Complications during labor/delivery (circle)? YES NO If YES answer the following:
   a. What complications? Respiratory distress Meconium aspiration
   Prolonged labor Prolapsed umbilical cord
   Cardiopulmonary abnormalities

Other (list): _____

_____

_____

b. C-section YES NO Planned Emergency

c. Apgar (list): 1-min. _____ 5-min._____ 10-min._____

HEALTH HISTORY (PERINATAL FACTORS; CONTINUED)

15. Neonatal surgery (circle): YES NO If YES answer the following:
    a. Reason for surgery? _____
    b. Outcome of surgery? _____
    c. Complications? _____

HEALTH HISTORY (INFANCY AND CHILDHOOD)

16. Childhood infections (circle)? Meningitis Encephalitis
    Other (list): _____

17. Childhood viruses (circle all that apply/list when illness occurred)? Mumps Chicken pox Ear infections
    Unexplained fever Other (list): _____

18. Medical Diagnoses/Issues (circle):
    Fetal alcohol syndrome Epilepsy
    Lead poisoning Pica
    Chronic ear infections Tube placement
    Immune dysfunction Thyroid problems
    Arthritis Rashes
    Allergy history Gastrointestinal symptoms
    Asthma Other (list): _____

19. Medications currently prescribed (list): _____

20. Vision Screening (list): Date: _____ Near 20/___ Far 20/___

21. Suspected hearing loss YES NO If YES describe reasons for concern: _____

22. Hearing Screening (list): Date: _____ Result: _____

FAMILY HISTORY

23. Siblings with AD/HD (circle)? YES NO
    a. Is sibling an identical twin? YES NO

24. Siblings with AD/HD-like behavior (circle)? YES NO
    a. Is sibling an identical twin? YES NO

25. Parent with AD/HD (circle)? YES NO
    a. Relationship to child (circle): biological father biological mother step-parent

26. Parent with AD/HD-like behavior (circle): YES NO
    a. Relationship to child (circle): biological father biological mother step-parent

27. Parent with antisocial behavior history or conduct disorder (circle)? YES NO
    a. Relationship to child (circle): biological father biological mother step-parent

28. Other family members with AD/HD (circle)? YES NO
    a. Relationship to child (list): _____

29. Other family members with AD/HD-like behavior (circle)? YES NO
    a. Relationship to child (list): _____

30. Other family members with antisocial behavior history or conduct disorder (circle)? YES NO
    a. Relationship to child (list): _____

31. Family history of alcoholism (circle)? YES NO

32. Highest paternal educational attainment (list) Mother _____ grade Father _____ grade

DEVELOPMENTAL HISTORY

33. Age major milestones were obtained (list)? First word _____ First steps _____
    Sentences _____ Walks alone _____
    Stands alone _____

BEHAVIORAL HISTORY

34. Abnormal eating or sleeping habits (list): _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____

BEHAVIORAL HISTORY (CONTINUED)[1]

35. Is/Was the child hyperactive and/or impulsive? YES NO If YES answer the following:

a. Early childhood: Does/Did the child runs in circles, not stopping to rest? _____
Does/Did the child may bang into objects or people? _____
Does/Did the child constantly ask questions? _____

NOTES: _____

_____

_____

DIAGNOSTIC NOTE: Young children in infancy and in the preschool years are normally very active and impulsive and may need constant supervision to avoid injury. Their constant activity may be stressful to adults who do not have the energy or patience to tolerate the behavior.

b. Middle childhood: Does/Did the child play active games for long periods? _____
Does/Did the child occasionally do things impulsively _____

NOTES: _____

_____

_____

DIAGNOSTIC NOTE: During school years and adolescence, activity may be high in play situations and impulsive behaviors may normally occur, especially in peer pressure situations.

c. Adolescence Does the adolescent engages in active social activities (e.g., dancing) for long periods? _____
Does the adolescent engage in risky behaviors w/ peers? _____

NOTES: _____

_____

_____

DIAGNOSTIC NOTE: High levels of hyperactive/impulsive behavior do not indicate a problem or disorder if the behavior does not impair function.

36. Is/Was the child inattentive? YES NO If YES answer the following:

a. Early childhood: Does/Did the preschooler has difficulty attending, except briefly, to a storybook or a quiet task such as coloring or drawing._____

NOTES: _____

_____

_____

DIAGNOSTIC NOTE: A young child will have a short attention span that will increase as the child matures. The inattention should be appropriate for the child's level of development and not cause any impairment.

b. Middle childhood: Does/Did the child fail to persist very long with a task the child does not want to do such as read an assigned book, homework, or a task that requires concentration such as cleaning something? _____

NOTES: _____

_____

_____

c. Adolescence Is the adolescent is easily distracted from tasks he or she does not desire to perform? _____

NOTES: _____

_____

_____

_____

[1]Adapted from American Academy of Pediatrics. (2000). Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder. *Pediatrics, 105*, 1158-1170.

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

ADHD ASSESSMENT STRATEGIES

The assessment of ADHD requires information from a variety of sources. In the clinic you are limited as to the different sources of information you are able to access. This protocol addresses ADHD referrals within the clinic and will be expanded when you are working in the field.

Source/Type	**Suggested methods**
Developmental history	Developmental questionnaire Parent interview Clinical Interview Form School records
Broad span behavior rating scale	Behavior Assessment System for Children Parent rating form Teacher rating form Self rating form Child Behavior Checklist Parent rating form Teacher rating form Self rating form Social Skills Rating Form Parent rating form Teacher rating form Self rating form
Narrow band behavior rating scale	ADHD Rating Scale – IV School Version Home Version
Observations	Clinical observations during assessment
General testing	Cognitive assessment of other broad abilities and general ability Developmental level Rule out learning disabilities Auditory processing Language difficulties
Attention specific assessments	Attention/planning clusters of: WJ III NEPSY CAS Other measures of attention and vigilance

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

PSYCHOEDUCATIONAL EVALUATION

[DATE OF REPORT]

NAME:	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATES:	TRACK:
AGE:	TEACHER:
PRIMARY LANGUAGE:	EXAMINER:

REASON FOR REFERRAL

Name was referred for testing by the Student Success Team (SST). It was hoped that this evaluation would aid in the determination of **his/her** special education eligibility. At the time of referral specific concerns included the following: (**From SST data list reasons for referral**). From this referring concern, the following suspected areas of disability were evaluated by this assessment: (**List all areas related to the suspected disability**).

It is important to note that before initiating this evaluation the effects of environmental, cultural, and economic disadvantage on this students' learning was evaluated. From the available data it was concluded (**Report conclusions regarding the effect of these variables on learning and, if necessary, justify the decision to proceed with a special education evaluation**).

PSYCHOEDUCATIONAL PROCEDURES [1, 2, 3, 4]

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) English was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level**?**). These data, combined with the Examiner's basic awareness of this student's cultural and ethnic background (**State how awareness was obtained.**), lead to the conclusion that it was appropriate for this Examiner to conduct this evaluation and to do so in English.

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) (**Primary language**), was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level **?**). Because of these data an interpreter, familiar with the cultural and ethnic background of this student, was used during testing.

[2] This assessment was completed in accordance with a judgment by Federal District Court Judge Robert Peckham (in response to C-71-2270 RFP, Larry P. vs. Riles), which bars the administration of certain tests to this student.

[3] Before beginning this assessment the Examiner ensured that the interpreter had received adequate training to act as an interpreter (**state qualifications**). Experiences within the testing sessions lead the Examiner to conclude that use of this interpreter facilitated attainment of valid test scores.

[4] All psycho-educational procedures were selected and administered so as not to be racially, culturally, or sexually discriminatory, and have been validated for the specific purposes for which they were used.

The following procedures were used to obtain a valid estimate of **Name's** psycho-educational functioning:

[Traditional assessment procedures]

*In analyzing these results it needs to be kept in mind that the tests listed above were generally standardized on (**standardization sample, e.g., monolingual English-speaking children**). Thus, for the purposes of special education placement, the scores are psychometrically invalid. Children with **Name**'s characteristics were not included in the test's standardization samples. The test scores do not necessarily indicate the presence of learning difficulties. However, they do give information regarding **Name**'s present level of functioning in the English-speaking classroom. These scores can be used for baseline and follow-up measures to assess progress in English. Test scores alone should not be used to justify placing **Name** into special education. Alternative assessment procedures used during this assessment included the following:*

[Alternative assessment procedures]

BACKGROUND INFORMATION

Data obtained from **Name**'s cumulative folder indicates (**Identify when the student first began to display symptoms of ADHD that interfered with educational functioning. Report the student's achievement levels, grade-level changes/retentions, discipline records, work habits, prior special program placements, prior referrals, number of schools attended, attendance record, and learning strengths and weaknesses.**)

Program Modifications

Educational interventions already attempted to meet **Name**'s educational needs within a less restrictive environment have included the following: (**e.g., specialist consultations, support services, minimum day, independent study, home teaching, suspension, alternate instructional methods, parent conferences/communication, etc.)**. At this time, these modifications **have/have no**t allowed **Name** to be successful in the general education program.

The following social interventions have been attempted: [**When appropriate list interventions (e.g., counseling) and their duration**. **Describe the outcome of these interventions**].

The following specific behavior interventions have been attempted: (**When appropriate list behavioral interventions and their duration**. **Describe the outcome of these interventions**).

Developmental and Health History

Pregnancy and birth history. During the parent interview **Name**'s mother/father/step-mother/step-father (**Parent's Name**) indicated that (**Describe pregnancy and birth history**). There **are/were no** reports of substance abuse during pregnancy, or oxygen depravation at the time of delivery.

Name was born at term/premature at (**Number of weeks gestation**) weeks gestation. Labor lasted (**Length of labor**) hours. Birth weight was (**Birth weight**). Problems reported to have occurred during the delivery included (**Problems during delivery. In particular note anoxia during birth.**). Birth weight was (**Birth Weight**). One and five minute APGAR scores were (**1 Min. Score**) and (**5 Min. Score**) respectively.

Major developmental milestones. Developmental milestones are reported to have been (**Report milestones**).

Health history. According to (**Data source**), prior to **his/her** diagnosis with (**chronic or acute health problem**), **Name's** health history was (**Describe history**). Recent school screenings (**Date**) suggest (**Vision**) vision and (**hearing**) hearing.

Family history. During the parent interview it was reported that there was no history of family members with learning or behavior difficulties

During the parent interview it was reported that there was a history of other cases of attention deficit disorder and/or learning disabilities within the family.

During the parent interview it was reported that there was a history of other family members with serious psychiatric disorders (e.g., schizophrenia or major depression).

PREVIOUS ASSESSMENT FINDINGS

Name was previously assessed in (**Date of previous testing**) by (**Examiner**). Results suggested (**Results**).

BEHAVIORAL ASSESSMENT

Behavior Ratings

Behavioral Observations

Classroom.

Playground.

Home.

Test Taking Behavior.

PSYCHOMETRIC ASSESSMENT

Intellectual Ability

Academic Functioning

Language Functioning

Social and Emotional Functioning

SUMMARY AND EDUCATIONAL IMPLICATIONS

Name is a (**CA**) (**Grade**) grade (**Gender**) who has been assessed to help determine **his/her** eligibility for special education assistance. At the time of referral specific concerns included (**Reasons for Referral**).

Name is a (**CA**) (**Grade**) grade (**Gender**) who has been assessed to help determine **his/her** eligibility for special education assistance. At the time of referral specific concerns included (**Reasons for Referral**).

Educationally relevant health and developmental findings include (**Discuss relevant findings**).

Environmental, cultural, and/or economic disadvantage have (**Discuss how these variables effect educational performance**).

Name's second language acquisition has affected **his/her** learning (**If appropriate discuss how language acquisition has influenced performance.**

Learning strengths would appear to include....

Learning weakness include....

Name's academic functioning would appear to be affecting **his/her** social functioning in the following ways: (**Describe this relationship**).

From the current battery of tests the following recommendations are made:

1. From this assessment it would appear that **Name** meets eligibility criteria as an individual with a specific learning disability. It would appear that these needs cannot be corrected without special education assistance. Specifically, **Name** has a disorder in the basic psychological processes of attention.

1. **Name** does **not** appear to meet eligibility criteria as an individual with a specific learning disability [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030 (j)]. This conclusion is based upon the following assessment finding(s):

   (a) It appears that **Name**'s learning needs can be met within the general education program.

   (b) It appears that environmental disadvantage plays a primary role in **Name**'s learning difficulties.

   (c) It appears that cultural disadvantage plays a primary role in **Name**'s learning difficulties.

   (d) It appears that economic disadvantage plays a primary role in **Name**'s learning difficulties.

   (e) It has been determined a lack of English proficiency plays a primary role in **Name**'s learning difficulties.

(f) It is concluded a temporary disability plays a primary role in **Name**'s learning difficulties.

(g) It appears that social maladjustment plays a primary role in **Name**'s learning difficulties.

(h) The available date suggests that a lack of instruction in (**reading and/or math**) plays a primary role in **Name**'s learning difficulties.

1. From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs. It would appear that these needs cannot be met without special education assistance. Specifically, **Name** has limited alertness, due to a chronic health problem (Attention-deficit/Hyperactivity Disorder), which adversely affects **his/her** educational performance.

1. **Name** does **not** appear to meet eligibility criteria as an individual with an Other Health Impairment [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030 (f)]. This conclusion is based upon the following assessment finding(s):

(a) There is insufficient data available to document the presence of an Attention-deficit/Hyperactivity Disorder.

(b) At this time the Attention-deficit/Hyperactivity Disorder would not appear to significantly adversely affect **Name**'s educational performance. This problem would not appear to limit **Name**'s ability to benefit from general education program instruction.

(c) According to (**site medical authority**), **Name**'s limited alertness is temporary in nature as defined by the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3001(af). This means that at the termination of the (**health problem**), **Name** can, without special intervention, reasonably be expected to return to his or her regular education class.

(d) Environmental, cultural, and/or economic disadvantage were judged to be a primary factor in **Name**'s poor academic **and/or** social functioning.

1. **Name** appears to meet appears to meet eligibility criteria as an individual with an emotional disturbance [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030(i)]. Specifically, because of an Attention-deficit/Hyperactivity Disorder, **Name** has exhibited the following characteristic(s) over a long period of time and to a marked degree, which adversely affect educational performance:

(a) An inability to learn which cannot be explained by intellectual, sensory, or health factors.

(b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(c) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations.

(d) A general pervasive mood of unhappiness or depression.

(e) A tendency to develop physical symptoms or fears associated with personal or school problems.

1. **Name** does **not** appear to meet eligibility criteria as an individual with an emotional disturbance [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030 (i)]. This conclusion is based upon the following assessment finding(s):

   (a) **Name** does not demonstrate symptoms of an emotional disturbance.

   (b) **Name** does not demonstrate any of the following characteristics:

      i) An inability to learn which cannot be explained by intellectual, sensory, or health factors.

      ii) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

      iii) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations.

      iv) A general pervasive mood of unhappiness or depression.

      v) A tendency to develop physical symptoms or fears associated with personal or school problems.

   (c) The characteristic(s) demonstrated by **Name** have not existed for a long period of time.

   (d) The characteristic(s) demonstrated by **Name** have not existed to a marked degree.

   (e) The characteristic(s) demonstrated by **Name** do not adversely affect educational performance.

2. Additional areas of suspected disability not addressed in by the current assessment include the following: From this observation the following additional assessments are recommended: (**List additional assessments that are judged required to address all areas of suspected disability, e.g., physical therapy, occupational therapy, recreational therapy, psychotherapy, etc. NOTE: the IEP meeting should not be held until these areas are assessed**).

3. Specific interventions recommended to address **Name**'s anticipated learning needs include the following:

4.

5.

The final decision as to whether or not **Name** meets special education eligibility will be made by the individualized education program team, including assessment personnel, and will take into account all relevant material which is available on **Name**. No single score or product of scores, test or procedure has been used as the sole criterion for the decision of the individualized education program team as to **his/her** eligibility for special education.

_____

Stephen E. Brock, Ph.D., NCSP
Licensed Educational Psychologist

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

AUTISM DIAGNOSTIC EVALUATION HEALTH, FAMILY, DEVELOPMENTAL, & BEHAVIORAL HISTORY INTERVIEW FORM

Child's Name: _____ Birth date: _____
School: _____ Grade: _____
Parent(s): _____ E-mail: _____
Home phone: _____ Alt. Phone: _____
Languages spoken in the home: _____
Siblings and their ages: _____
Other adults living in the home: _____

Referring concern: _____
_____
_____
_____
_____
_____

At what age did the referring concerns first emerge? _____

HEALTH HISTORY (PERINATAL FACTORS)

1. General obstetric status (circle one): Optimal Adequate Poor

2. Mothers age time of the pregnancy (list): _____

3. Length of pregnancy (circle/list): Full term Premature @ _____weeks

4. Was there threatened miscarriage (circle)? YES NO If YES describe below:

   _____
   _____
   _____

5. Maternal illnesses during the pregnancy (circle all that apply/list when illness occurred):

   Measles _____ Mumps _____ Rubella _____
   Influenza _____ Syphilis _____ Herpes _____
   HIV _____ Cytomegalovirus _____
   Other (list): _____
   _____
   _____

HEALTH HISTORY (PERINATAL FACTORS CONTINUED)

6. Alcohol exposure during pregnancy (circle): YES NO If YES answer the following:
   a. How often did mother drink? Every day Once a week Rarely
   b. How much did mother drink? Just a little One drink Several drinks
   c. When during pregnancy did mother drink? 1st trimester 2nd Trimester 3rd trimester

7. Drug exposure during pregnancy (circle): YES NO If YES answer the following:
   a. What drugs were taken? Thalidomide Depakene Depakote
   Other (list): _____
   _____
   _____
   _____
   b. When during pregnancy were drugs taken? 1st trimester 2nd Trimester 3rd trimester

8. Complications during delivery (circle)? YES NO If YES answer the following:
   a. What complications? Respiratory distress
   Meconium aspiration
   Other (list): _____
   _____
   _____
   _____
   b. C-section YES NO Planned Emergency
   c. 1-min. Apgar (list): _____
   d. 5-min. Apgar (list): _____
   e. 10-min. Apgar (list): _____

9. Birth weight (list): _____lbs. _____oz.

10. Length (list): _____inches

HEALTH HISTORY (INFANCY AND CHILDHOOD)

11. Head circumference (list): _____inches at birth _____%ile at birth
    _____inches at 1 year _____%ile at 1 year
    _____inches at 2 years _____%ile at 2 years
    _____inches at 3 years
    ___%ile at 3 years _____inches at 4 years
    _____%ile at 4 years _____inches at 5 years _____%ile at 5 years

12. Childhood infections (circle all that (apply/list when illness occurred)? Meningitis ____ Encephalitis ____
    Other (list): _____
    _____
    _____
    _____

HEALTH HISTORY (INFANCY AND CHILDHOOD CONTINUED)

13. Childhood viruses (circle all that Apply/list when illness occurred)?
Mumps Chicken pox ____ Ear infections _____
Unexplained fever Other (list): _____
_____
_____
_____

14. Medical Diagnoses/Issues (circle):

Tuberous sclerosis	Fragile X syndrome
Fetal alcohol syndrome	Epilepsy
Lead poisoning	Pica
Chronic ear infections	Tube placement
Immune dysfunction	Thyroid problems
Arthritis	Rashes
Allergy history	Gastrointestinal symptoms
Hydrocephalus	Cerebral palsy
Mental retardation	Other (list): _____

_____
_____
_____

15. Vision Screening (list): Date: _____ Near 20/___ Far 20/___

16. Suspected hearing loss YES NO If YES describe reasons for concern: _____
_____

17. Hearing Screening (list): Date: _____ Result: _____

FAMILY HISTORY

18. Siblings with autism (circle)? YES NO If YES answer the following:
    a. Is sibling an identical twin? YES NO

19. Siblings with autism-like behavior (circle)? YES NO If YES answer the following:
    a. Is sibling an identical twin? YES NO

20. Family members with autism (circle)? YES NO If YES answer the following:
    a. Relationship to child (list): _____

21. Family members with autism-like behavior (circle)? YES NO If YES answer the following:
    a. Relationship to child (list): _____

FAMILY HISTORY (CONTINUED)

21. Other health/developmental problems among family members (circle)?
Epilepsy Mental retardation
Other (list): _____

22. Family history of genetic disorders
Tuberous sclerosis Fragile X syndrome
Schizophrenia Anxiety
Bipolar disorder Depression
Other (list): _____

DEVELOPMENTAL HISTORY

23. Age major milestones were obtained (list)?
First word _____
Sentences _____
Stands alone _____
First steps _____
Walks alone _____

24. Developmental regression observed (circle)? YES NO If YES answer the following:
a. Age regression observed (list): _____
b. Describe the regression (list): _____

BEHAVIORAL HISTORY

25. Unusual sensory sensitivities (circle)? YES NO If YES answer the following:
a. Over sensitive to stimuli (list): _____
b. Unusually interested in stimuli: (list): _____

26. Abnormal eating or sleeping habits (list): _____

27. Unusual fearfulness of harmless object (list): _____

BEHAVIORAL HISTORY (CONTINUED)

28. Lack of fear for real dangers (list): _____
_____
_____

29. Self-injurious behaviors (list): _____
_____
_____

30. Socialization questions:

Does the child…[3]

a. cuddle like other children? _____
b. look at you when you are talking or playing? _____
c. smile in response to a smile from others? _____
d. engage in reciprocal, back-and-forth play? _____
e. play simple imitation games, such as pat-a-cake or peek-a boo? _____
f. show interest in other children? _____

31. Communication questions:

Does the child…[1]

a. point with his or her finger? _____
b. gesture (e.g., non yes and no)? _____
c. direct your attention by holding up objects for you to see? _____
d. show things to people? _____
e. give inconsistent response to his or her name (or to commands)? _____
f. use rote, repetitive, or echolalic speech? _____
g. memorize strings of words or scripts? _____

32. Stereotyped behavior questions:

Does the child…[1]

a. have repetitive, stereotyped, or odd motor behavior? _____
b. have preoccupations or a narrow range of interests? _____
c. attend more to parts of an object (e.g., the wheels of a toy car)? _____
d. have limited or absent pretend play? _____
e. Imitate other people's actions? _____
f. play with toys in the same exact way every time? _____
g. appear strongly attached to a specific unusual object(s)? _____

[3] Adapted from Filipek (1999).

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

SAMPLE PSYCHO-EDUCATIONAL REPORT RECOMMENDATIONS FOR THE STUDENT WITH AUTISM

Stephen E. Brock, Kim Silva, Annie Riffey, Silvia Ludena
California State University Sacramento
Paper Presented at the 58th Annual, 2007 CASP Convention,Los Angeles, CA, March 9, 2007

From a review of the literature regarding the school psychologist's role in identifying, assessing, and treating autism spectrum disorders (ASD; Brock, Jimerson, & Hansen, 2006), we have identified interventions often recommended when addressing some of the specific challenges associated with these disorders. This presentation, and the following handout, offers some of these recommendations (along with the accompanying background information) that we feel you might find useful when writing a psycho-educational report. It is important to acknowledge that without a careful assessment of specific student needs this document will not be helpful. However, following a comprehensive psycho-educational evaluation, and the identification of specific student needs, we feel that this information will be helpful in stimulating your thinking about appropriate psycho-educational report recommendations for the student with ASD.

Social Relations

If the student is challenged by social situations, then the following intervention and support recommendations might be appropriate:

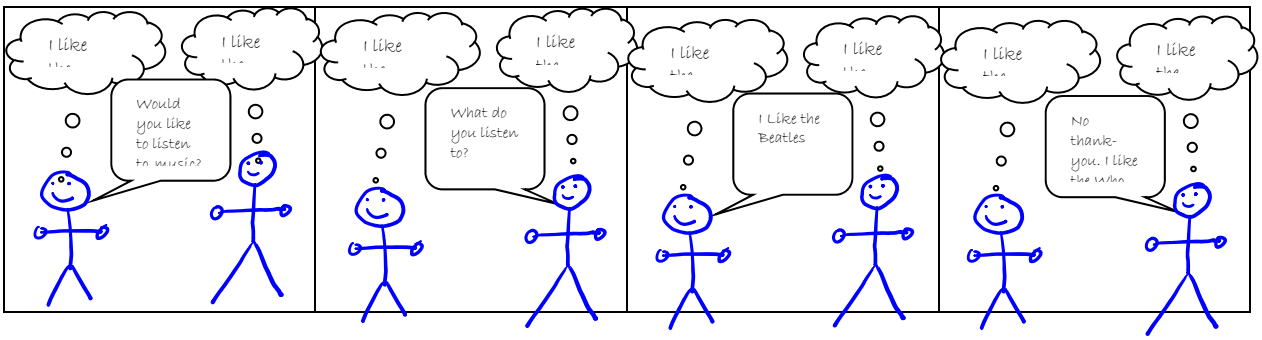
1. Provide interpretation of social situations. Specifically, the following are suggested:
    a. Make use of social stories™ (Gray & White, 2002). A social story is a short story that explains a specific challenging social situation. The goal is to find out what is happening in a situation. The following is an example of a social story:

> When Other Students Get Upset
> Sometimes other students get upset and cry.
> When this happens their teacher might try to help them.
> The teacher might try to help them by talking to them or holding them.
> This is okay.
> Sometimes when other students get upset and cry, it makes me upset and angry.
> I can use words to tell my teacher that I am upset.
> I can say, "That makes me mad!" or "I'm upset!"
> It is okay to use words about how I feel.
> When I get upset I will try to use words about how I feel.

        i. For more information about social stories go to
            - http://www.thegraycenter.org/
            - http://www.polyxo.com/socialstories/introduction.html

ii. A variety of sample stories can be found at
    - http://www.frsd.k12.nj.us/autistic/Social%20Stories/social_stories.htm

b. Use cartooning to illustrate the rules of challenging social situations (Myles & Simpson, 2001). For example, …



c. Explain problematic social situations and in doing so let NAME know that there are specific choices to be made and that each choice has a specific consequence. Specific steps in this process (as described by Myles & Simpson, 2001) are as follows:
    i. Help NAME understand the problematic social situation (i.e., who was involved, what happened, etc.).
    ii. Facilitate NAME's brainstorming of options for responding to the situation.
    iii. Help NAME explore the consequences for each option identified.
    iv. Help NAME identify the response that has the most desirable consequences.
    v. Develop and action plan.
    vi. Practice the response to the problematic social situation by role playing, visualizing, writing a plan, or talking it out with a peer.

d. To address NAME's difficulty making friends, the following interventions are recommended:
    i. Establish structured activities with peers. These activities should have pre-assigned roles that can be practiced.
    ii. Provide direct instruction on how to approach an individual or group.
    iii. Provide direct instruction on the skills needed to interact with peers.
    iv. Structure social opportunities around NAME's special interests.

e. After a challenging social situation conduct a "social autopsy" (Myles & Simpson, 2001). Such a conversation involves an examination and inspection of NAME's social errors to discover their causes, better understand the consequences of such errors, and to decide what can be done to prevent it from happening again.

f. Identify specific social conventions that need to be taught and then provide direct instruction. Examples, of social conventions that NAME may need to be taught include the following (**LIST HERE SPECIFIC SOCIAL RULES THAT THE ASSESSMENT DATA SUGGESTS MAY NEED TO BE TAUGHT. EXAMPLES INCLUDE THE FOLOWING**):
    i. "Do not ask to be invited to someone's party
    ii. Speak to teachers in a pleasant tone of voice because they will respond to you in a more positive manner. They also like it if you smile every once in a while.
    iii. Do not correct someone's grammar when he or she is angry.
    iv. Never break laws – no matter what your reason.
    v. When your teacher gives you a warning about your behavior and you continue the behavior, realize that you probably are going to get in trouble. If you stop the behavior immediately after the first warning, you will probably not get in trouble.
    vi. Do not touch someone's hair even if you think it is pretty.
    vii. Do not ask friends to do things that will get them in trouble.

viii. Understand that different teachers may have different rules for their classes.
ix. Do not draw violent scenes.
x. Do not sit in a chair that someone else is sitting in – even if it is 'your' chair.
xi. Do not argue with a policeman – even if you are right.
xii. Do not tell someone you want to get to know better that he or she has bad breath.
xiii. Do not try to do what actors do on television or the movies. These shows are not the same as real life.
xiv. Do not pick flowers from someone's garden without permission, even if they are beautiful and you want to give them to someone" (Myles & Simpson, 2001, p. 8).

g. Make use of NAME's special interests to develop "power cards" that facilitate the understanding of social rules (Myles & Simpson, 2001). **(TRY TO LINK THE STUDENTS SPECIAL INTERESTS TO PROBLEMATIC SOCIAL SITUATIONS.)** For example, make use of NAME's interest in automotive mechanics and provide him/her with the following card that can be placed on his/her desk and/or in his/her pocket.

Automotive mechanics and students both…
1) listen to people when they tell them that something is wrong.
2) ask good questions to make sure they understand the problem.
3) try to solve problems.

Communication

If the student has difficulties with expressive language, then the following might be appropriate:

1. Consider making use of a Picture Exchange Communication System (PECS; Frost & Bondy, 1994; Preis, 2006). PECS is a picture based communication system wherein the student gives a picture or symbol of a desired item in exchange for the item itself. The intent of PECS is to assist the student in developing spontaneous communication. The following are examples of PECS symbols:

a. Sample PECS IEP objectives can be found at http://www.pecs.com/Brochures/Objectives/IEP%20Objectives%202002.pdf
b. PECS pictures and photos can be found at http://www.childrenwithspecialneeds.com/downloads/pecs.html
c. Blank PECS image grids, and daily and weekly picture card schedule forms can be found at http://www.do2learn.com/picturecards/forms/index.htm
d. For more information about PECS go to
   i. http://www.bbbautism.com/pecs_contents.htm
   ii. http://www.polyxo.com/visualsupport/pecs.html
   iii. http://www.usd.edu/cd/autism/topicpages/printer/PECS.pdf

iv. http://www.nas.org.uk/nas/jsp/polopoly.jsp?d=297&a=3642&view=print
v. http://www.iidc.indiana.edu/irca/communication/WhatisthePEC.html

e. Specific PECS cards should include the following (**AS INDICATED BY ASSESSMENT DATA):**
   i. "Break" Cards that assist NAME in communicating when he/she needs to escape a task or situation.
   ii. "Choice" cards that provide NAME some control by indicating a choice from a prearranged set of possibilities.
   iii. "All done" cards that assist NAME in communicating when he/she is finished with an activity or task.
   iv. "Turn-taking" cards that can be used to visually represent and mark whose turn it is.
   v. "Wait" cards that can be used to visually teach the concept of waiting.
   vi. "Help" cards that assist in teaching NAME to raise his/her hand to indicate the need for assistance.

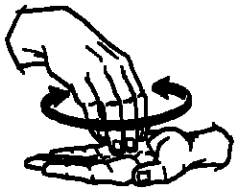
If the student has difficulties with receptive language, then the following might be appropriate:

1. Consider using a Picture Exchange Communication System (Preis, 2006) paired with a verbal command.
   a. When giving a verbal command, hand NAME the corresponding PECS icon at the same time the verbal command is given. This will provide NAME with both a verbal and visual cue to assist him/her in understanding what is expected of him/her.
   b. Providing paired verbal and visual cues with PECS will increase NAME's generalization of language concepts across environments (i.e., people and settings).

If the student has difficulties with receptive and expressive vocabulary, then the following might be appropriate:

1. Consider using total communication to teach and speak to NAME (Goldstein, 2002). The following strategy is recommended:
   a. When speaking to NAME, pair your speech with the appropriate corresponding sign. For example, …

Say: **"Cookie"** and make the sign below



**** To make the sign:*** The right hand, in the 'C'  position, palm down, is placed into the open left palm. It then rises a bit, swings or twists around a little, and in this new position is placed again in the open left palm.

   b. For more information about how to use sign language go to http://commtechlab.msu.edu/sites/aslweb/browser.htm

1. Consider using the Prelinguistic Milieu Training (PMT) with NAME (Goldstein, 2002). Specific PMT strategies (as described by McCathren, 2000) include the following:
    a. Following NAME's attentional leads (i.e., talking about and playing with NAME's focus of interest).
    b. Using prompts for communication (i.e., asking for specific behaviors).
    c. Using behavioral and vocal imitation (e.g., NAME claps and vocalizes, adult claps and vocalizes).
    d. Modeling conventional gestures (i.e., pointing, nodding) and vocalizations with consonants.
    e. Developing play routines (i.e., rolling a toy truck back and forth, etc.).
    f. Changing the environmental arrangement.
    g. For more information on Prelinguistic Milieu Training (PMT) go to http://childconnections.tripod.com/id13.html.

If the student has difficulties initiating conversation with others, then the following might be appropriate:

1. Consider pairing NAME with a peer tutor during social play time (Whitaker, 2004). The following strategies are recommended:
    a. Provide NAME with a structured play time during which highly desirable toys are provided.
    b. Have the peer tutor participate with NAME during the structured play time.
    c. Have the peer tutor get close to NAME during the play time, follow NAME's lead during the play time, talk slowly and simply to NAME, and make the play time fun.
    d. Have the peer tutor join in any activity that NAME spontaneously chooses.

If the student has difficulties initiating or sustaining conversation with others, then the following might be appropriate:

1. Consider using a cue card/written script program to develop conversational skills. Specific steps in this program (as described by Charlop-Christy & Kelso, 2003) are as follows:
    a. Sit across from NAME and ask him/her the initial conversation question for a predetermined conversation. For example, …

> **Teacher:** Do you like to play games?
> **Child:** Yes. Do you like games?
> **Teacher:** Yes. What's your favorite game?
> **Child:** Mr. Mouth. What game do you like?
> **Teacher:** Candy Land. Are you good at playing games?
> **Child:** Yes. Can we play together?
> **Teacher:** Sure!

    b. Immediately present NAME with a cue card upon which a scripted response and question are written and ask NAME to "read it out loud."
    c. Next, ask NAME to repeat the scripted line to you (e.g., teacher, classroom assistant, etc.) while maintaining eye contact.
    d. Repeat the above procedure for each of NAME's lines in the conversation.
    e. Upon correct completion of the conversation, give NAME reinforcement (e.g., praise, a high five, etc.) for good reading, sitting, and attention.
    f. Next, remove all cue cards and ask NAME the initial conversation question again.

Challenging Behaviors

If disruptive behavior problems are present, then the following might be appropriate:

1. Functional behavioral assessment is recommended.
    a. Students with autism frequently engage in disruptive behaviors to escape demands and gain or maintain access to perseverative items and activities (Reese, Richnam, Zarcone, & Zarcone, 2003). Thus, the focus of any functional assessment should include special attention to perseverative behaviors that might serve to obtain desirable sensory stimuli.
    b. Students with autism also frequently engage in disruptive behaviors to escape aversive sensory stimuli (Reese et al., 2003). Thus, the focus of any functional assessment should also direct attention to perseverative behaviors that might serve to escape from aversive sensory stimuli.
    c. From the functional behavioral assessment, determine if differential reinforcement of alternative, other, or incompatible behavior will be necessary. The technique employed should derive from the behavioral assessment (Dozier, Iwata, & Neidert, 2005).

If a student needs predictability (e.g., becomes anxious when new materials/activities are introduced), then the following might be appropriate:

1. Employ "priming" (Myles & Adreon, 2001). This involves showing the actual instructional materials that will be used in a lesson the day, evening, or morning before the given classroom activity is going to take place. Priming should be brief (10 to 15 minutes) and built into NAME's daily schedule and should take place in a relaxing environment.
2. Employ a visual schedule of new tasks (Dettmer, Simpson, Myles, & Ganz, 2000). This involves showing the student a pictographic sequence of the events that will unfold. The schedule should give NAME information of the activity and when it will be finished.
3. Employ the use of social stories (Edwards, Rabian, Scattone, & Wilczynski, 2002). This involves informing NAME of the new events that will be experienced and appropriate ways to act in these situations.

If disruptive behavior problems are present and known to be related to perseverative activities, then the following might be appropriate (Reese et al., 2003):

1. Identify and decrease environmental and/or physiological conditions that are related to perseverative behavior.
2. Determine if the behavior is an attempt to avoid aversive sensory stimulation or a strategy to obtain desirable sensory stimulation.

If disruptive behaviors appear to be related to anxiety and/or a desire to avoid aversive sensory stimulation, then the following might be appropriate (Reese et al., 2003):

1. The problem (perseverative) behaviors appear to have a calming or organizing effect and might be related to anxiety. Thus, the following strategies are recommended as they appear to reduce anxiety (and in doing so may decrease the need for the perseverative behaviors):
    a. Establish predictable routines
    b. Use visual schedules to facilitate coping with change
    c. Practice alternative coping behaviors such as relaxation

If disruptive behaviors appear to be related to obtaining desirable sensory stimulation, then the following might be appropriate (Reese et al., 2003):

1. The problem (perseverative) behavior(s) appear to be positively reinforcing. Thus, the following strategies are recommended:
    1. Provide appropriate access to the desired sensory stimulation on a regular basis. Provide instruction on how to appropriately obtain the desired stimuli. This will decrease the need to engage in behaviors that have as their function obtaining the stimuli.
    2. Providing contingent access to the desired sensory stimulation may be used as a positive reinforcer for the completion of instructional tasks.

Further recommendations for students whose sensory issues are judged to play a role in specific problem behaviors include the following (adapted from Myles, Cook, Miller, Rinner, & Robbins, 2000):

1. To address NAME's problems making eye contact, the following interventions are recommended:
    a. Consider decreasing expectations for eye contact in some situations.
    b. Try to place speakers in NAME's line of sight with out getting too close
    c. Strive to provide minimal auditory information and/or offer slight touch to encourage visual attention
2. To address NAME's difficulties understanding body language and/or facial expressions the, following interventions are recommended:
    a. Provide auditory cues to direct NAME's attention.
    b. Try to eliminate irrelevant background distractions.
    c. Strive to pair facial expressions, gestures, and body language with words.
    d. Strive to be cognizant of unspoken social cues when giving instructions.
3. To address NAME's difficulty transitioning in hallways, the following interventions are recommended:
    a. Allow NAME to be either first or last in line.
    b. Allow NAME to leave class early.
    c. Have NAME carry something heavy to provide proprioceptive input.
4. To address NAME's constant humming, the following interventions are recommended:
    a. Move NAME away from noise sources that may be distressing
    b. Allow NAME to hum, but teach him/her that such is appropriate only in certain situations (e.g., to help him/her concentrate) and try to get him/her to do it more quietly.
5. To address NAME's desire to touch, the following interventions are recommended:
    a. Before NAME enters a new environment specify exactly what can/cannot be touched.
    b. Before NAME enters a new environment provide deep pressure by rubbing his/her shoulder, back, or palms.
6. To address NAME's messy handwriting, the following interventions are recommended:
    a. Have NAME engage in gross-motor activities before being asked to perform fine-motor tasks.
    b. Encourage NAME to engage in activities that develop hand strength.
    c. Have NAME write on raised-line paper
    d. Teach NAME keyboarding skills.

Academic Functioning

If the student has weaknesses in, attention, organizational, transitional, and auditory processing, then the following might be appropriate:

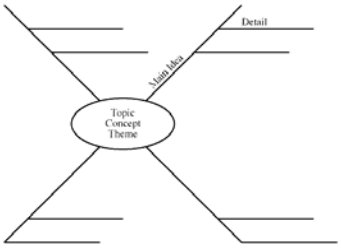
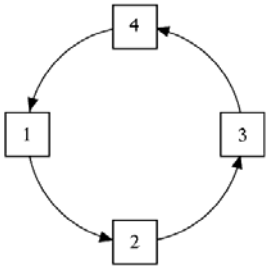
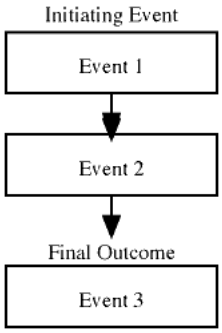
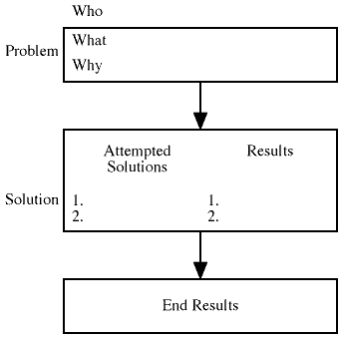
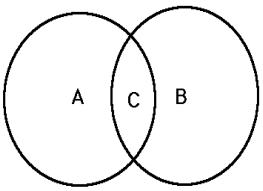
1. To address NAME's poor organizational skills, the following interventions are recommended (adapted from Myles, Cook, Miller, Rinner, & Robbins, 2000):
    a. Provide as much visual structure as is possible

    b. Use tape and labels to specify where instructional materials are to be placed.
2. To address NAME's difficulty with change, the following interventions are recommended(adapted from Myles, Cook, Miller, Rinner, & Robbins, 2000):
    a. Offer a signal before transitions take place
    b. Use visual cues to prepare NAME for what will happen next
    c. Allow NAME to obtain deep pressure
    d. Give NAME a script or social story to follow whenever an unexpected event takes place.
3. The instructional program should center on NAME's strengths (TYPICALLY ROTE MEMORY AND VISUAL PROCESSING), special interests, and needs (Dettmer et al., 2000; Quill, 1997). It may include the following:
    a. Visual schedules that depict the student's daily routine
    b. Work systems
    c. Calendars to help the student understand when regularly scheduled events may occur
    d. To facilitate transitions, make use of visual cues that forewarn the student when something is going to end, stop or be all done. This assists in transitions. This can be done with a visual count down timer.
    e. Place classroom rules in a visual form on the student's desk.
    f. Place strong visual cues throughout the classroom to guide the student through physical space.
        i. Use boundary markers such as barriers, rugs, bookcases, other furniture, or colored tape on the floor to represent boundaries of areas for play and study.
        ii. Use movable signs to mark spaces that are used for a particular purpose at a specific time.
        iii. Store common classroom materials (e.g., school supplies, games) on accessible shelves or in see through storage containers. When needed, provide labels for these materials (using pictures paired with words).
    g. Use visual cues in instruction (e.g., hands-on demonstrations and modeling, objects, pictures) as needed to help NAME better grasp the directions.
    h. Use strategies to make directions and learning expectations clearly understood.
        i. Include essential and concrete information in directions that will answer: (1) *How much work is there to do in this task?* (2) *What exactly am I supposed to do?* (3) *When do I do the work?* (4) Wh*at is my payoff for doing the work?* (Volmer, 1995).

If a student has reading fluency and/or comprehension difficulties, then the following might be appropriate:

1. Highlighted text
2. Study guides
3. Graphic Organizers (Pictorial representations may be substituted for words; Ae-Hwa Kim, 2004).

Graphic Organizer Examples

<table>
<tr>
<td>Network Tree
</td>
<td>Spider
 
</td>
<td>Cycle
 
</td>
</tr>
<tr>
<td>Chain of Events
 
</td>
<td>Problem/ Solution
 
</td>
<td>Venn Diagram
 
</td>
</tr>
</table>

If a student has written expression (e.g., handwriting) difficulties, then the following might be appropriate:

1. When assessing NAME's content knowledge allow for verbal, instead of written responses.
2. When completing written assignments allow NAME to use the computer instead of pen or pencil.
3. Multiple-choice tests can be used instead of short answer to assess subject matter knowledge.
4. Allow NAME to create projects, rather than producing written reports.

If a student has difficulty with note taking, then the following might be appropriate:

1. Provide NAME with a complete outline including the main idea and supporting details of a lesson or lecture.
2. Provide NAME with a skeletal outline that he/she can use to fill in details.
3. Provide NAME with a peer copy of the notes

Alternative Treatments

If parents are interested in other treatments to help reduce symptoms or behaviors associated with autism, then the following is a list of recommendations that may be a part of a comprehensive treatment plan. However, the school psychologist should treat these recommendations with caution, as there is limited research to support their effectiveness, and they would NOT typically appear in the psycho-educational report.

If the student exhibits behavioral problems, then the following vitamin supplements might be recommended (Levy & Hyman, 2002):

- Combination of vitamin B6 and magnesium
- Vitamin C
- Vitamin A

If the student exhibits behavioral problems, then the following medications might be recommended (Levy & Hyman, 2002; http://www.fda.gov/bbs/topics/NEWS/2006/NEW01485.html):

- Secretin
- Risperdal

For regulation of immune function, the following treatments might be recommended (Levy & Hyman, 2002):

- Antibiotic
- Antifungal
- Antiviral Medications
- Probiotics
- Intravenous human immune globulin
- Vitamin A supplementation
- Withholding of vaccines

For control or improvement of symptoms of autism, the following might be recommended (Levy & Hyman, 2002):

- Gluten-free/casein-diet
- Chelatin/Mercury-detoxification

If the student is sensitive to sound, then the following might be appropriate (Levy & Hyman, 2002):

- Use of auditory integration to decrease the sensitivity to sound through systematic exposure to altered music by headphones.

If the student experiences communication challenges, then the following might be recommended (Levy & Hyman, 2002):

- Use of facilitated communication.

If the student exhibits behavior problems, then the following might be recommended (Levy & Hyman, 2002):

- Use of craniosacral manipulation.

References

Ae-Hwa Kim, B. A., Vaughn, S., Wanzek, J., & Shangjin, J. (2004). Graphic organizers and their effects on the reading comprehension of students with LD: A synthesis of research. *Journal of Learning Disabilities, 37,* 105-118.

Brock, S. E., Jimerson, S. R., & Hansen, R. L. (2006). *Identifying, assessing, and treating autism at school.* New York: Springer.

Charlop-Christy, M., & Kelso, S. (2003). Teaching children with autism conversational speech using a cue card/written script program. *Education and Treatment of Children, 26,* 108-119.

Dettmer, S., Simpson, R. L., Myles, B. S., & Ganz, J. B. (2000). The use of visual supports to facilitate transitions of students with autism. *Focus on Autism and Other Developmental Disabilities*, *15,* 163-169.

Dozier, C.L., Iwata, B. A., & Neidert, P. L. (2005). Treatment of multiply controlled problem behavior with procedural variations of differential reinforcement. *Exceptionality, 13*(1), 45-53.

Edwards, R. P., Rabian, B., Scattone, D., & Wilczynski, S. M. (2002). Decreasing disruptive behaviors of children with autism using social stories. *Journal of Autism and Developmental Disorders, 32,* 535-543.

Frost, L., & Bondy, A. (1994). *The picture exchange communication system training manual.* Cherry Hill, NJ: PECS.

Goldstein, H. (2002). Communication intervention for children with autism: A review of treatment efficacy. *Journal of Autism and Developmental Disorders, 32,* 373-396.

Gray, C., & White, A. L. (2002). *My social stories book.* Gateshead, Great Britain: Arthenaeum Press.

Levy, S., & Hyman, S. (2002). Alternative/complementary approaches to treatment of children with autistic spectrum disorders. *Infants and Young Children, 14,* 33-42.

McCathren, R. (2000). Teacher implemented prelinguistic communication intervention. *Focus on Autism and Other Developmental Disabilities, 15,* 21-29.

Myles, B. S., & Adreon, D. (2001). *Asperger syndrome and adolescence: Practical solutions for school success.* Shawnee Mission, KS: AAPC.

Myles, B. S., Cook, K. T., Miller, N. E., Rinner, L., & Robbins, L. A. (2000). *Asperger syndrome and sensory issues: Practical solutions for making sense of the world.* Shawnee Mission, KS: AAPC.

Myles, B. S., & Simpson, R. L. (2001, November). Effective practices for students with Asperger syndrome. *Focus on Exceptional Children, 34*(3), 1-14.

Preis, J. (2006). The effect of picture communication symbols on the verbal comprehension of commands by young children with autism. *Focus on Autism and Other Developmental Disabilities, 21,* 194-210.

Quill, K. A. (1997). Instructional considerations for young children with autism: The rational for visually cued instruction. *Journal of Autism and Developmental Disorders, 27,* 697-714.

Reese, R. M., Richnam, D. M., Zarcone, J., & Zarcone, T. (2003). Individualizing functional assessments for children with autism: The contribution of perseverative behavior and sensory disturbances to disruptive behavior. *Focus on Autism and Other Developmental Disabilities, 18,* 87-92.

Volmer, L. (1995). Best practices in working with students with autism. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology* (3rd ed., pp. 1031-1038). Bethesda, MD: National Association of School Psychologists.

Whitaker, P. (2004). Fostering communication and shared play between mainstream peers and children with autism: Approaches, outcomes, and experiences. *British Journal of Special Education, 31,* 215-222.

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

PSYCHO-EDUCATIONAL EVALUATION
[DATE OF REPORT]

NAME:	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATES:	TRACK:
AGE:	TEACHER:
PRIMARY LANGUAGE:	EXAMINER:

REASON FOR REFERRAL

Name was referred for testing by the Student Success Team (SST). It was hoped that this evaluation would aid in the determination of **his/her** special education eligibility. At the time of referral specific concerns included the following: (**From SST data list reasons for referral**). From this referring concern, the suspected area of disability addressed by the current psycho-educational evaluation is "autism" [Title 5, CCR §3030(1)].

It is important to note that before initiating this evaluation the effects of environmental, cultural, and economic disadvantage on this students' learning was evaluated. From the available data it was concluded (**Report conclusions regarding the effect of these variables on learning and, if necessary, justify the decision to proceed with a special education evaluation**).

PSYCHO-EDUCATIONAL PROCEDURES [1, 2, 3, 4]

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) English was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level**?**). These data, combined with the Examiner's basic awareness of this student's cultural and ethnic background (**State how awareness was obtained.**), lead to the conclusion that it was appropriate for this Examiner to conduct this evaluation and to do so in English.

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) (**Primary language**), was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level **?**). Because of these data an interpreter, familiar with the cultural and ethnic background of this student, was used during testing.

[2] This assessment was completed in accordance with a judgment by Federal District Court Judge Robert Peckham (in response to C-71-2270 RFP, Larry P. vs. Riles), which bars the administration of certain tests to this student.

[3] Before beginning this assessment the Examiner ensured that the interpreter had received adequate training to act as an interpreter (**state qualifications**). Experiences within the testing sessions lead the Examiner to conclude that use of this interpreter facilitated attainment of valid test scores.

[4] All psycho-educational procedures were selected and administered so as not to be racially, culturally, or sexually discriminatory, and have been validated for the specific purposes for which they were used.

The following procedures were judged to provide valid estimates of **Name**'s psycho-educational functioning. They have been selected to assess specific areas of educational need and to assist the IEP team in determining **Name**'s eligibility for special education assistance:

[As indicated list traditional assessment procedures]

*In analyzing these results it needs to be kept in mind that the tests listed above were generally standardized on (**standardization sample, e.g., monolingual English-speaking children**). Thus, for the purposes of special education placement, the scores are psychometrically invalid. Children with **Name**'s characteristics were not included in the test's standardization samples. The test scores do not necessarily indicate the presence of learning difficulties. However, they do give information regarding **Name**'s present level of functioning in the English-speaking classroom. These scores can be used for baseline and follow-up measures to assess progress in English. Test scores alone should not be used to justify placing **Name** into special education. Alternative assessment procedures used during this assessment included the following:*

[As indicated list alternative assessment procedures]

BACKGROUND INFORMATION

Name is a (**grade level**) grade **boy/girl** who attends (**School name**) School. Born in (**Birthplace**) **he/she** currently resides with **his/her** natural **parents/mother/father/step-mother/step-fathe**r in **City**, California. **S/he** has (**Number of sibs**). (**Mother's name**) is employed as a (**Mother's occupation**) and **his/her (Father's name)** is employed as a (**Father's occupation**). The primary language of the home is (**Language**).

Parent reports indicate **Name**'s current health status to be **excellent/good/fair/poor**. Current health concerns include (**List current health concerns**). Medications currently prescribed include (**list medications**).

Vision assessment [**Date(s) of screenings**] indicates 20/(**Acuity**) in both eyes. 20/(**Acuity**) vision in the right eye and 20/(**Acuity**) in the left eye. Glasses **have/have not** been prescribed. Hearing assessment [**Date(s) of screenings**] indicates **(report results of screening)**.

PREVIOUS TESTING

Name was previously assessed in (**Date of previous testing**) by (**Examiner**). Results suggested (**Results**).

PREGNANCY & BIRTH HISTORY

During the parent interview **Name**'s (**Parent's Name**) indicated that the mother was (**age**) at the time of this student's birth. There were no significant problems during the pregnancy. Nor were there reports of maternal infections or drug exposure during pregnancy, or birth complications.

During the parent interview **Name**'s (**Parent's Name**) indicated that the mother was (**age**) at the time of this student's birth. Prenatal maternal infections were reported and included (**list infections**). Prenatal drug exposure included (**list drugs/medications taken during pregnancy**).

Perinatally, **Name** was born at term. Labor lasted (**Length Of Labor**) hours and the birth proceeded without significant incident. Birth weight was (**Birth Weight**). One and five minute APGAR scores were (**1 minute score**) and (**5 minute score**) respectively.

Perinatally, **Name** was born premature at (**Number Of Weeks Gestation**) weeks gestation. Birth weight was (**Birth Weight**). One and five minute APGAR scores were (**1 minute score**) and (**5 minute score**) respectively. Labor lasted (**Length Of Labor**) hours and the birth was complicated by (**List problems during delivery. In particular note anoxia during birth.**).

DEVELOPMENTAL HISTORY

Parental report indicates that developmental milestones were obtained within normal limits. No developmental regression was reported

All developmental milestones appear to have been obtained outside normal limits. **Name** said his/her first word at (**First Word**) months, began combining words into sentences at (**Sentences**) months, crawled at (**Crawled**) months, and walked at (**Walked**) months. Toilet Training occurred at (**Toilet**) months. Socially, (**Describe Social Development**). Parent reports **did/did not** suggest developmental regression (**As indicated describe regression**).

While **Name**'s speech/motor milestones appear were delayed, speech /motor milestones were obtained within normal limits. **Name** said his/her first word at (**First Word**) months, began combining words into sentences at (**Sentences**) months, crawled at (**Crawled**) months, and walked at (**Walked**) months. Toilet Training occurred at (**Toilet**) months. Socially, (**Describe Social Development**). Parent reports **did/did not** suggest developmental regression (**As indicated describe regression**).

HEALTH HISTORY

(**Parent**) indicates **Name**'s health history since birth to be without significant incident.

(**Parent**) indicates **Name**'s health during infancy to have been **excellent/good/fair/poo**r. Health concerns during this time included (**Look for chronic ear infections, immune dysfunction, autoimmune disorders, allergies, gastrointestinal symptoms**). Specific illnesses included (**Look for the occurrence of encephalitis, meningitis, mumps, chickenpox**).

Name's health during the preschool years is reported to have been **excellent/good /fair/poor**. Health concerns during this time included (**Look for chronic ear infections, immune dysfunction, autoimmune disorders, allergies, gastrointestinal symptoms**). Specific illnesses included (**Look for the occurrence of encephalitis, meningitis, mumps, chickenpox**).

Since enrolling in school (**Parent**) reports **Name**'s health status to have been **excellent/good/fair/poor**. Health concerns since enrolling in kindergarten have included (**Look for chronic ear infections, immune dysfunction, autoimmune disorders, allergies, gastrointestinal symptoms**).

DIAGNOSTIC HISTORY

During the parent interview it was reported that there was **Name**'s diagnostic history was unremarkable.

During the parent interview it was reported that **Name**'s diagnostic history includes the following: (**List general medical and/or neurological conditions. Look for tuberous sclerosis, fragile X syndrome, mental retardation, epilepsy**).

FAMILY HISTORY

During the parent interview it was reported that there was no history of family members with autism or related disorders. (**Specify disorder and relationship to student**)

During the parent interview it was reported that there was a history of other cases of autism, PDD, or learning disabilities (especially language difficulties) within the family. (**Specify disorder and relationship to student**)

During the parent interview it was reported that there was a history of other family members with odd personality traits (especially poor social skills). (**Specify disorder and relationship to student**)

During the parent interview it was reported that there was a history of other family members with serious psychiatric disorders (e.g., schizophrenia or major depression). (**Specify disorder and relationship to student**)

SCHOOL & TREATMENT HISTORY

Name had (**Years Of Preschool**) years of preschool experience. **Name** did not have any preschool experiences. **Name** has spent **his/her** entire school career at (**School**) Elementary School. **Name** has attended (**Number Of Schools Attended**) different schools during **his/her** school career. **S/he** began his/her school career at (**First School Attended**). **S/he** first enrolled at (**Current School**) School (**Date First Enrolled**). **Name**'s school attendance history is **excellent/good/fair/poor**.

Previous teacher comments contained within school records (**Cum Comments**).

INDIRECT BEHAVIORAL ASSESSMENTS

(**Report the results of behavior rating scales and structured interviews**)

DIRECT BEHAVIORAL ASSESSMENTS

CLASSROOM OBSERVATIONS

(**Note any signs of reciprocal social interactions, verbal and nonverbal communication skills, and restricted, repetitive, and stereotyped pattern of behavior, interests, and activities**).

PLAYGROUND OBSERVATIONS

(**Note any signs of reciprocal social interactions, verbal and nonverbal communication skills, and restricted, repetitive, and stereotyped pattern of behavior, interests, and activities**).

HOME OBSERVATIONS

(**Note any signs of reciprocal social interactions, verbal and nonverbal communication skills, and restricted, repetitive, and stereotyped pattern of behavior, interests, and activities**).

TEST TAKING BEHAVIOR

Name readily accompanied the examiner to the testing room and rapport appeared to be adequate. Rapport was questionable (**Discuss relatedness with the examiner. Mention eye contact**). Level of activity and verbalizations were appropriate to the tasks at hand. **His/Her** reaction to failure was (**Reaction to failure**). Encouragement and praise resulted in (**Result of praise**). **Name**'s effort was **consistent./inconsistent**. **Name**'s behavior upon reunion with **his/her** parents was (**Natural, spontaneously approaches parents or is such contact guided by parent? Makes physical contact with parent? How long is contact sustained? Eye contact with parent?**). Results are considered a valid reflection of **his/her** present level of functioning.

PSYCHOMETRIC ASSESSMENT

COGNITIVE FUNCTIONING

ADAPTIVE BEHAVIOR

ACADEMIC FUNCTIONING

BASIC PSYCHOLOGICAL PROCESSES

LANGUAGE FUNCTIONING

EMOTIONAL FUNCTIONING

SUMMARY AND EDUCATIONAL IMPLICATIONS

Name is a (**CA**) (**Grade**) grade (**Gender**) who has been assessed to help determine **his/her** eligibility for special education assistance. At the time of referral specific concerns included (**Reasons for Referral**).

Educationally relevant health and developmental findings include (**Discuss relevant findings**).

Environmental, cultural, and/or economic disadvantage have (**Discuss how these variables effect educational performance**).

Name's second language acquisition has affected **his/her** learning (**If appropriate discuss how language acquisition has influenced performance.**

Learning strengths would appear to include....

Learning weakness include....

Name's academic functioning would appear to be affecting **his/her** social functioning in the following ways: (**Describe this relationship**).

From the current battery of tests the following conclusions and recommendations are made:

1. From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(1)]. **He/She** exhibits significant verbal and nonverbal communication, and social interaction deficits. These challenges were evident early in **Name**'s development and are judged to significantly adversely affect **his/her** educational performance. These difficulties are not primarily due to an emotional disturbance (as defined in CCR, Title 5). Other characteristics associated with Autism and displayed by **Name** include: **engagement in repetitive activities and stereotyped movements**, **resistance to environmental change or change in daily routines**, and **unusual responses to sensory experiences**. *[NOTE: these associated characteristics are listed in §3030(b)(1), but are not specified as being required for eligibility as a student with autism.]*

2. Additional areas of suspected disability not addressed in by the current assessment include the following: From this observation the following additional assessments are recommended: (**List additional assessments that are judged required to address all areas of suspected disability, e.g., physical therapy, occupational therapy, recreational therapy, psychotherapy, etc. NOTE: the IEP meeting should not be held until these areas are assessed**).

3. Specific interventions recommended addressing **Name**'s anticipated learning needs, which should facilitate success in the least restrictive environment, include the following:

   i)

   ii)

   iii)

4.

The final decision as to whether or not **Name** meets special education eligibility will be made by the individualized education program team, including assessment personnel, and will take into account all relevant material which is available on **Name**. No single score or product of scores, test or procedure has been used as the sole criterion for the decision of the individualized education program team as to **his/her** eligibility for special education.

_____

Stephen E. Brock, Ph.D., NCSP
Licensed Educational Psychologist

EDUCATION CODE SECTIONS RELATED TO AUTISM CRITERIA
CCR 3030 - Eligibility Criteria

(a) A child shall qualify as an individual with exceptional needs, pursuant to Education Code section 56026, if the results of the assessment as required by Education Code section 56320 demonstrate that the degree of the child's impairment as described in subdivisions (b)(1) through (b)(13) requires special education in one or more of the program options authorized by Education Code section 56361. The decision as to whether or not the assessment results demonstrate that the degree of the child's impairment requires special education shall be made by the IEP team, including personnel in accordance with Education Code section 56341(b). The IEP team shall take into account all the relevant material which is available on the child. No single score or product of scores shall be used as the sole criterion for the decision of the IEP team as to the child's eligibility for special education.

(1) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, and adversely affecting a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.
(A) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in subdivision (b)(4) of this section.
(B) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in subdivision (b)(1) of this section are satisfied.

30 EC 56030.5 - Definition of Severely Disabled

"Severely disabled" means individuals with exceptional needs who require intensive instruction and training in programs serving pupils with the following profound disabilities: Autism, blindness, deafness, severe orthopedic impairments, serious emotional disturbances, severe mental retardation, and those individuals who would have been eligible for enrollment in a development center for handicapped pupils under Chapter 6 (commencing with Section 56800) of this part, as it read on January 1, 1980.

EMOTIONAL DISTURBANCE

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

PSYCHO-EDUCATIONAL EVALUATION

[DATE OF REPORT]

NAME:	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATES:	TRACK:
AGE:	TEACHER:
PRIMARY LANGUAGE:	EXAMINER:

REASON FOR REFERRAL

Name was referred for testing by the Student Success Team (SST). It was hoped that this evaluation would aid in the determination of **his/her** special education eligibility. At the time of referral specific concerns included the following: (**From SST data list reasons for referral**). From this referring concern, the following suspected areas of disability were evaluated by this assessment: (**List all areas related to the suspected disability**).

It is important to note that before initiating this evaluation the effects of environmental, cultural, and economic disadvantage on this students' learning was evaluated. From the available data it was concluded (**Report conclusions regarding the effect of these variables on learning and, if necessary, justify the decision to proceed with a special education evaluation**).

PSYCHOEDUCATIONAL PROCEDURES [1, 2, 3, 4]

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) English was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level**?**). These data, combined with the Examiner's basic awareness of this student's cultural and ethnic background (**State how awareness was obtained.**), lead to the conclusion that it was appropriate for this Examiner to conduct this evaluation and to do so in English.

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) (**Primary language**), was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level **?**). Because of these data an interpreter, familiar with the cultural and ethnic background of this student, was used during testing.

[2] This assessment was completed in accordance with a judgment by Federal District Court Judge Robert Peckham (in response to C-71-2270 RFP, Larry P. vs. Riles), which bars the administration of certain tests to this student.

[3] Before beginning this assessment the Examiner ensured that the interpreter had received adequate training to act as an interpreter (**state qualifications**). Experiences within the testing sessions lead the Examiner to conclude that use of this interpreter facilitated attainment of valid test scores.

[4] All psycho-educational procedures were selected and administered so as not to be racially, culturally, or sexually discriminatory, and have been validated for the specific purposes for which they were used.

The following procedures were used to obtain a valid estimate of **Name's** psycho-educational functioning:

[Traditional assessment procedures]

*In analyzing these results it needs to be kept in mind that the tests listed above were generally standardized on (**standardization sample, e.g., monolingual English-speaking children**). Thus, for the purposes of special education placement, the scores are psychometrically invalid. Children with **Name**'s characteristics were not included in the test's standardization samples. The test scores do not necessarily indicate the presence of learning difficulties. However, they do give information regarding **Name**'s present level of functioning in the English-speaking classroom. These scores can be used for baseline and follow-up measures to assess progress in English. Test scores alone should not be used to justify placing **Name** into special education. Alternative assessment procedures used during this assessment included the following:*

[Alternative assessment procedures]

BACKGROUND INFORMATION

Data obtained from **Name**'s cumulative folder indicates (**Report the student's achievement levels, grade-level changes/retentions, discipline records, work habits, prior special program placements, prior referrals, number of schools attended, attendance record, and learning strengths and weaknesses.**)

Program Modifications

Educational interventions previously attempted to meet **Name**'s educational needs within a less restrictive environment have included the following: (**e.g., specialist consultations, support services, minimum day, independent study, home teaching, suspension, alternate instructional methods, parent conferences/communication, etc.)**. At this time, these modifications **have/have no**t allowed **Name** to be successful in the general education program.

The following interventions have been attempted to address **Name**'s social and emotional needs: [**List interventions (e.g., counseling) and their duration**. **Describe the outcome of these interventions**].

The following specific behavior interventions have been attempted: (**List behavioral interventions and their duration**. **Describe the outcome of these interventions**).

DEVELOPMENTAL AND HEALTH HISTORY

Pregnancy and birth history. During the parent interview **Name**'s **mother/father/step-mother/step-father** (**Parent's Name**) indicated that (**Describe pregnancy and birth history**).

Major developmental milestones. Developmental milestones are reported to have been (**Report milestones**).

Health history. According to (**Data source**), prior to **his/her** diagnosis with (**chronic or acute health problem**), **Name's** health history was (**Describe history**). Recent school screenings (**Date**) suggest (**Vision**) vision and (**hearing**) hearing.

Current health status. Recent vision and hearing screening results (**date**) suggest 20/**??** vision and **??** hearing.

PREVIOUS ASSESSMENT FINDINGS

Name was previously assessed in (**Date of Previous Testing**) by (**Examiner**). Results suggested (**Results**).

ASSESSMENT DATA

INTERVIEWS

Caregiver interview(s).

Teacher interview(s).

Student interviews.

BEHAVIORAL OBSERVATIONS.

Behavior rating scale(s).

Adaptive Behavior

Classroom.

Playground.

Home and community.

Test taking behavior.

INTELLECTUAL TESTING

ACADEMIC TESTING

ASSESSMENT OF BASIC PSYCHOLOGICAL PROCESSES

Auditory processing.

Visual processing.

Sensory motor integration.

Memory.

Attention.

EMOTIONAL FUNCTIONING

Projective techniques. (**e.g., sentence completion, three wishes, drawings, etc.**)

Objective techniques. (**e.g., CBCL, BASC-2, PIC-R, etc.**)

SUMMARY AND EDUCATIONAL IMPLICATIONS

Name is a (**CA**) (**Grade**) grade (**Gender**) who has been assessed to help determine **his/her** eligibility for special education assistance. At the time of referral specific concerns included (**Reasons for Referral**).

Educationally relevant health and developmental findings include (**Discuss relevant findings**).

Environmental, cultural, and/or economic disadvantage have (**Discuss how these variables effect educational performance**).

Assessment data suggests (**Discuss results of intellectual, academic, and other tests. Identify student strengths and weaknesses.**). Learning strengths would appear to include.... Learning weakness include....

Data relevant to **Name**'s emotional functioning reveals [**address the presence or absence of an emotional disturbance, address the presence or absence of specific characteristics of the emotional disturbance, and specify whether the characteristics have existed for a long period of time (6 months or longer) to a marked degree, and whether they adversely affect educational performance**]. [**NOTE**: See Appendix A for a further discussion of these factors.)

From the current battery of tests the following conclusions and recommendations are made:

1. **Name** appears to meet appears to meet eligibility criteria as an individual with an **Name** appears to meet appears to meet eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(4)]. From this assessment it has been suggested that **Name** has an emotional condition, *[NOTE: as indicated specified the emotional condition* **here***]* that results in the following characteristic**(s)**: *[NOTE: only one of the following is required, but if a student displays more than one list all that apply]*
    (A) An inability to learn which cannot be explained by intellectual, sensory, or health factors.
    (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
    (C) Inappropriate types of behavior or feelings under normal circumstances.
    (D) A general pervasive mood of unhappiness or depression.
    (E) A tendency to develop physical symptoms or fears associated with personal or school problems.

   This/These challenges have existed for a long period of time, to a marked degree, and adversely affect **Name**'s educational performance. **This/These** challenges are not solely due to social maladjustment.

1. **Name** does **not** appear to meet eligibility criteria as an individual with an emotional disturbance [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030 (i)]. This conclusion is based upon the following assessment finding(s):

    (i) **Name** does not demonstrate symptoms of an emotional disturbance.

    (ii) **Name** does not demonstrate any of the following characteristics:

a) An inability to learn which cannot be explained by intellectual, sensory, or health factors.

b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

c) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations.

d) A general pervasive mood of unhappiness or depression.

e) A tendency to develop physical symptoms or fears associated with personal or school problems.

(iii) The characteristic(s) demonstrated by **Name** have not existed for a long period of time.

(iv) The characteristic(s) demonstrated by **Name** have not existed to a marked degree.

(v) The characteristic(s) demonstrated by **Name** do not adversely affect educational performance.

3. Additional areas of suspected disability not addressed in by the current assessment include the following: From this observation the following additional assessments are recommended: (**List additional assessments that are judged required to address all areas of suspected disability, e.g., physical therapy, occupational therapy, recreational therapy, psychotherapy, etc. NOTE: the IEP meeting should not be held until these areas are assessed**).

3. Specific interventions recommended to address **Name**'s anticipated learning needs, which should facilitate success in the least restrictive environment, include the following:

(i)

(ii)

(iii)

4.

5.

These results will be reported to the Individual Educational Planning (IEP) Team. The IEP Team will make the decision as to whether or not these data demonstrate that Name requires special education. This team will take into account all the relevant material available on **Name**. No single test or other data source will be used as the sole criterion to determine **Name**'s special education eligibility.

_____

Stephen E. Brock, Ph.D., NCSP
Licensed Educational Psychologist

KEY ISSUES IN DETERMINING EMOTIONAL DISTURBANCE ELIGIBILITY

The following is adapted from "Identification and Assessment of the Seriously Emotionally Disturbed Child: A Manual for Educational and Mental Health Professionals."

1. **An emotional condition.** For any child to be classified as being emotional disturbed (ED) there must be a serious emotional condition from which specific behavioral and/or emotional characteristics stem. Isolated behaviors or expressions of emotionality in and of themselves do not constitute ED.

2. **For a long period of time.** Unless otherwise specified in DSM IV-TR, the specific characteristics (which are the result of a serious emotional condition) must have been demonstrated for a period of at least six (6) months. A shorter duration may be suggestive of temporary adjustment difficulties. In addition, a shorter duration will not typically give the general education program sufficient opportunity to attempt to meet the student's needs in a less restrictive environment.

3. **To a marked degree.** The specific characteristics (which are the result of a serious emotional condition) must be demonstrated to a marked degree. This means that they are (a) pervasive (seen/reported across a variety of settings, i.e., home, school, and community), and (b) intense (produce significant distress for the student and among others in the student's environments).

4. **Significantly adversely affect educational performance.** The specific characteristics (which are the result of a serious emotional condition) result in the student not being able to benefit from general education program instruction. Ways to document such a result include statistically significant ability/achievement discrepancies, quality and degree of task completion and on-task behavior, and grade reports. More subjective data sources (e.g., teacher reports) must be supported by independent observations (e.g., at least two observations by the school psychologist). (NOTE: an adverse effect can be assumed if the student is presently considered to be a danger to self or others).

5. **The primary handicap.** The identified ED must be considered the student's primary handicap. If it is judged to be a secondary problem, than the primary handicap should be used as the rational for special education eligibility.

6. **An inability to learn which cannot be explained by intellectual, sensory, or other health factors.** As a result of a specific serious emotional condition (other than schizophrenic symptomatology which is addressed elsewhere in "inappropriate types of behavior or feelings…" characteristic) the student cannot learn. Such inability is not due to behavioral, motivational, cognitive, cultural, sensory, or other health problems (all of which are ruled out as the primary cause of the student's difficulties by the assessment data).

7. **An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.** The student is unable to initiate or maintain relationships. Such inability is not due to social maladjustment, withdrawal, aggression, or immaturity. It is not the result of the student being unwilling to have relationships or lacking the social skills to do so. The student has social skills, wants to have interpersonal relationships, but is unable to do so.

8. **Inappropriate types of behaviors of feelings under normal circumstances.** This characteristic is typically reserved for those students who are psychotic, overtly bizarre, and/or a danger to themselves and/or others. Examples of behaviors that reflect this characteristic include catastrophic reactions to normal events, self-injurious behavior, responses to delusions or hallucinations, severe anxiety reactions, and extreme emotional lability.

9. **A general pervasive mood of unhappiness or depression.** This characteristic is typically reserved for those students who display symptoms of depression.

10. **A tendency to develop physical symptoms or fears associated with personal or school problems.** As a result of a specific serious emotional condition (e.g., somatoform disorders and anxiety disorders) the student demonstrates physical symptoms (e.g., headaches, stomachaches, etc., that do not have an organic etiology) and irrational fears (e.g., phobias) of particular objects, activities, individuals, or situations (that result in significant anxiety and/or avoidance behaviors).

EDUCATION CODE SECTIONS RELATED TO EMOTIONAL DISTURBANCE CRITERIA

5 CCR 3030 - Eligibility Criteria

(a) A child shall qualify as an individual with exceptional needs, pursuant to Education Code section 56026, if the results of the assessment as required by Education Code section 56320 demonstrate that the degree of the child's impairment as described in subdivisions (b)(1) through (b)(13) requires special education in one or more of the program options authorized by Education Code section 56361. The decision as to whether or not the assessment results demonstrate that the degree of the child's impairment requires special education shall be made by the IEP team, including personnel in accordance with Education Code section 56341(b). The IEP team shall take into account all the relevant material which is available on the child. No single score or product of scores shall be used as the sole criterion for the decision of the IEP team as to the child's eligibility for special education.

(4) Emotional disturbance means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(C) Inappropriate types of behavior or feelings under normal circumstances.
(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.
(F) Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under subdivision (b)(4) of this section.

30 EC 56339 - SPECIAL EDUCATION AND RELATED SERVICES INSTRUCTIONAL PROGRAM PROVIDED IN REGULAR EDUCATION PROGRAM

(a) **A pupil whose educational performance is adversely affected by a suspected or diagnosed attention deficit disorder or attention deficit hyperactivity disorder and demonstrates a need for special education and related services by meeting eligibility criteria** specified in subdivision (f) or (i) of Section 3030 of Title 5 of the California Code of Regulations or Section 56337 and subdivision (j) of Section 3030 of Title 5 of the California Code of Regulations for the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 and following) **categories of** "other health impairments," "**Serious Emotional Disturbance**," or "specific learning disabilities," is entitled to special education and related services.

(b) If a pupil with an attention deficit disorder or attention deficit hyperactivity disorder is not found to be eligible for special education and related services pursuant to subdivision (a), the pupil's instructional program shall be provided in the regular education program.

(c) It is the intent of the Legislature that local educational agencies promote coordination between special education and regular education programs to ensure that all pupils, including those with attention deficit disorders or attention deficit hyperactivity disorders, receive appropriate instructional interventions.

(d) It is further the intent of the Legislature that regular education teachers and other personnel be trained to develop an awareness about attention deficit disorders and attention deficit hyperactivity disorders and the manifestations of those disorders, and the adaptations that can be implemented in regular education programs to address the instructional needs of pupils having these disorders.

2 CCR 60045 - ASSESSMENT TO DETERMINE THE NEED FOR MENTAL HEALTH SERVICES

Assessment to Determine the Need for Mental Health Services.

(a) Within five (5) days of receipt of a referral, pursuant to subsections (a), (c) or (g) of Section 60040, the community mental health service shall review the recommendation for a mental health assessment and determine if such an assessment is necessary.

(1) If no mental health assessment is determined to be necessary, or the referral is inappropriate, the reasons shall be documented by the community mental health service. The community mental health service shall notify the parent and the LEA of this determination within one (1) working day.

(2) If the referral is determined to be incomplete, the reasons shall be documented by the community mental health service. The community mental health service shall notify the LEA within one (1) working day and return the referral.

(b) If a mental health assessment is determined to be necessary, the community mental health service shall notify the LEA, develop a mental health assessment plan, and provide the plan and a consent form to the parent, within 15 days of receiving the referral from the LEA, pursuant to Section 56321 of the Education Code. The assessment plan shall include, but is not limited to, the review of the pupil's school records and assessment reports and observation of the pupil in the educational setting, when appropriate.

(c) The community mental health service shall report back to the referring LEA or IEP team within 30 days from the date of the receipt of the referral by the community mental health service if no parental consent for a mental health assessment has been obtained.

(d) Upon receipt of the parent's written consent for a mental health assessment, the community mental health shall contact the LEA within one (1) working day to establish the date of the IEP meeting. The LEA shall schedule the IEP meeting to be held within fifty (50) days from the receipt of the written consent pursuant to Section 56344 of the Education Code.

(e) The mental health assessment shall be completed in sufficient time to ensure that an IEP meeting is held within fifty (50) days from the receipt of the written parental consent for the assessment. This time line may only be extended upon the written request of the parent.

(f) The community mental health service assessor shall review and discuss their mental health service recommendation with the parent and appropriate members of the IEP team. The assessor shall also make a copy of the mental health service assessment report available to the parent at least two days prior to the IEP team meeting.

(1) If the parent disagrees with the assessor's mental health service recommendation, the community mental health service shall provide the parent with written notification that they may require the assessor to attend the IEP team meeting to discuss the recommendation. The assessor shall attend the meeting if requested to do so by the parent.

(2) Following the discussion and review of the community mental health service assessor's recommendation, it shall be the recommendation of the IEP team members attending on behalf of the LEA.

(g) The community mental health service shall provide to the IEP team a written assessment report in accordance with Education Code Section 56327.

(h) For pupils with disabilities receiving services under this Chapter, the community mental health service of the county of origin shall be responsible for preparing statutorily required IEP reassessments in compliance with the requirements of this Section.

[Authority cited: Section 7587, Government Code] [Reference: Sections 56321, 56327 and 56344, Education Code]

GATE

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

GIFTED AND TALENTED EDUCATION PROGRAM ELIGIBILITY ASSESSMENT OUTLINE

[DATE OF REPORT]

NAME:	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATES:	TRACK:
AGE:	TEACHER:
PRIMARY LANGUAGE:	EXAMINER:

REASON FOR REFERRAL:
- Be specific about the issues.
- Focus the referral question so you can literally answer it in the summary.
- Note who initiated referral (parent/teacher/child/both)
- You might also include any relevant information as to why it was made (e.g. Cora's mother reports that Cora is reading and doing math at an advanced level….)

BACKGROUND INFORMATION:
- Note only those things that are relevant
- Be brief
- Try to give a picture of the child
- Note that information is reported by someone (usually parent)
- Family constellation
- Include health history
- Include developmental history
- Hearing and vision screening

PRIOR ASSESSMENT
- Provide a summary of any previous testing
- Refer reader to previous reports if needed

METHODS OF DATA COLLECTION:
Parent Interview
Woodcock Johnson Tests of Cognitive Abilities III
Clinical Observations

BEHAVIOR DURING TESTING:
- Behavioral observations are critical, take notes on your protocols
- Give examples of behaviors
- Make a statement here or in next section about validity of results.

- Do not diagnose from the behaviors you see

COGNITIVE FUNCTIONING:
- Discuss tests in terms of CHC theory
- Make a statement about confidence intervals and report scores with confidence intervals.
- Present information simply and clearly
- Use sub-headings if necessary
- Opinions vary as to whether to include test results here or in a separate table at the end. This semester put all scores in a separate table. You may include cluster (broad ability) in body of report if you wish.
- For any clusters with significantly different narrow abilities you must note separate narrow abilities.

SUMMARY and RECOMMENDATIONS
- Make sure the summary is a "summary." Briefly summarize test results with groupings of any cluster scores.
- Note any particular strengths/weaknesses in terms of observations/test results
- Go back to the referral question and answer it or state why you can't (e.g. limited information, needs further referral to determine).
- This may often be the only part people read, so make sure it is written clearly and succinctly and carries all relevant information in a brief form.
- Recommendations may be very brief or you make actually have none separate from summary.

_____	_____
(your name)	(Supervisor's name)
School Psychology Graduate Student	Supervising School Psychologist

Also note:
1. Each page should have child's name and page number, preferably in upper right corner.
2. cc copies to parent and to whomever else you are asked by parents, **and receive permission,** to send to.
3. Make two copies, one for parent and one for file.
4.Make sure copies get signed and stamped before you give one to parent.

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

GIFTED AND TALENTED EDUCATION PROGRAM ELIGIBILITY ASSESSMENT EXAMPLE 1

April 6, 2005

NAME: AT	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATE:	TRACK:
AGE: 7 years, 8 months	TEACHER:
PRIMARY LANGUAGE: English	EXAMINER:

Reason for Referral

AT was referred to the CSUS diagnostic clinic by the GATE Administrator at Unified School District. AT was referred because her IOWA test scores are on the border of GATE eligibility. AT's father, Mr. T, is interested in her eligibility for a GATE program.

Background Information

AT is a seven-year-old girl who lives with her parents andhas no siblings. T reports that AT enjoys drawing and telling stories and gets along well with her peers. He also states that AT enjoys all sports, especially karate and soccer. .

AT is currently in the second grade at Elementary School in the School District. Mr. T reports that she is particularly strong in the areas of reading and spelling. Comprehension is a challenge for AT; Mr. T states that she tests well in everything but comprehension. Miss M, AT's current teacher, reports that AT is a conscientious student with a creative imagination.

According to Mr. T, AT is a healthy seven-year-old who walked and spoke at a normal age. Currently, AT's hearing is normal and she wears glasses. There have been no recent stressful changes or events in her family.

Prior Assessment

AT previously participated in the IOWA Test of Basic Skills.

Methods of Data Collection

- Parent Interview
- Behavioral Observations
- Woodcock Johnson Tests of Cognitive Abilities III

Behavior During Testing

AT appeared to enjoy herself throughout the testing process. She actively engaged in conversation and was eager to share information about her life. She worked hard on each subtest and stated that she enjoyed testing. She particularly enjoyed the idea that she was helping college students with their studies. Mr. T previously explained to the examiner that AT was nervous about the testing and that acknowledging her help throughout the testing process would be beneficial to her success. During testing, AT often stopped to tell a story about people in her life and activities she likes to do. She was particularly interested in sharing information about her pets. AT and the examiner often talked about her love of dogs.

At times throughout the initial subtests, AT became upset when she thought that she did not perform well. As the questions became harder, the examiner reassured AT that the test was difficult and that she only needed to try her best. After this, AT appeared to relax and worked diligently on each subtest. These scores are considered a valid measure of AT's current intellectual functioning.

Cognitive Functioning

The Woodcock Johnson Tests of Cognitive Abilities III (WJIII COG) is a comprehensive assessment tool designed to provide an overall measure of cognitive abilities. It can be used to provide information on overall intellectual ability and to identify specific strengths and weaknesses in cognitive abilities.

AT was administered fourteen subtests that make up four broad clusters: General Intellectual Ability, Verbal Ability, Thinking Ability, and Cognitive Efficiency. Each of these clusters measure specific cognitive abilities.

When assessing children using standardized tests, a degree of error is associated with the test scores. If AT were to retake the WJIII COG again, there is a slight chance that her test scores would be different. To account for this error, her scores have been interpreted with a 90% confidence interval. This interval provides a range of scores from which AT's true score will fall nine out of ten times.

General Intellectual Ability

AT's GIA score of 133 (with a 90% confidence interval the score is expected to fall between 129-137) places her at the 99th percentile. Her overall intellectual functioning is in the very superior range.

Verbal Ability

The Verbal Ability cluster measures AT's ability to learn from her environment and communicate previously learned knowledge. This cluster is made up of the broad ability of Comprehension-Knowledge, which consists of the subtests of Verbal Comprehension and General Information. These tests assess AT's vocabulary and language development.

In the Verbal Ability cluster, AT's score of 112 (105-119) places her in the high average range. Her score places her in the 79th percentile.

Thinking Ability

The Thinking Ability cluster consists of a combination of cognitive abilites that are involved when information in short-term memory cannot be automatically processed. This cluster is made up of the broad abilities of Long-Term Retrieval, Visual-Spatial Thinking, Auditory Processing, and Fluid Reasoning. AT's thinking ability score of 124 (118-129) places her in the superior range. Her score places her in the 94th percentile.

AT's ability to store and retrieve information in long-term memory is in the very superior range. Her Long-Term Retrieval score of 130 (120-141) places her in the 98th percentile.

On tests that measure AT's ability to perceive and manipulate visual objects, she scored in the average range. Her Visual-Spatial Thinking score of 110 (103-118) places her in the 75th percentile.

AT's score on tasks that involve blending and detecting differences among speech sounds places her in the high average range. Her Auditory Processing score of 116 (106-126) places her in the 86th percentile.

On tasks involving problem-solving and use of novel information, AT is in the high average range. Her Fluid Reasoning score of 120 (113-126) places her in the 91st percentile.

Cognitive Efficiency

The Cognitive Efficiency cluster is a measure of AT's ability to process information automatically. This cluster is made up of two broad abilities, Processing Speed and Short-Term Memory. AT's Cognitive Efficiency score of 142 (135-149) places her in the very superior range and the 99th percentile.

AT's ability to rapidly process information when her attention is focused is in the superior range. Her Processing Speed score of 122 (116-128) places her in the 93rd percentile.

AT shows great strength in tasks involving holding information in short-term memory and using it quickly thereafter. She scored significantly better on these tasks than on others measured. AT's Short-Term Memory score of 149 (140-159) places her at greater than the 99th percentile. This score is in the very superior range.

Summary and Recommendations

AT was friendly and cooperative throughout the entire testing process. She worked diligently and put great effort into each subtest. When comparing AT's broad ability scores, a significant strength lies in the area of short-term memory. She performed particularly well on tasks that involve holding information in short-term memory and using it after a brief period of time.

AT's GIA score of 133 (99th percentile) places her in the very superior range. This score meets the commonly accepted criteria for GATE eligibility. Further discussion needs to occur between AT, her parents, and teachers to determine an appropriate academic placement.

Thank you very much for this opportunity to work with such a bright and interesting child.

_____ _____

School Psychology Graduate Student Catherine Christo, Ph.D., NCSP

Professor, CSUS

ABILITY CLUSTERS & SUBTESTS	STANDARD SCORE (90% Confidence Band)	PERCENTILE
GENERAL INTELLECTUAL ABILITY	Very Superior 133 (129-137)	99th
VERBAL ABILITY	High Average 112 (105-119)	79th
Comprehension-Knowledge	High Average 112 (105-119)	79th
Verbal Comprehension	Superior 121 (112-130)	92nd
General Information	Average 102 (92-112)	55th
THINKING ABILITY	Superior 124 (118-129)	94th
Long-Term Retrieval	Very Superior 130 (120-141)	98th
Visual-Auditory Learning	Superior 124 (113-135)	95th
Retrieval Fluency	High Average 120 (110-130)	91st
Visual-Spatial Thinking	Average 110 (103-118)	75th
Spatial Relations	Average 110 (102-118)	75th
Picture Recognition	Average 106 (98-114)	66th
Auditory Processing	High Average 116 (106-126)	86th
Sound Blending	Average 106 (95-118)	66th
Auditory Attention	Superior 122 (111-133)	93rd
Fluid Reasoning	High Average 120 (113-126)	91st
Concept Formation	High Average 114 (107-120)	82nd
Analysis-Synthesis	Superior 123 (113-132)	94th
COGNITIVE EFFICIENCY	Very Superior 142 (135-149)	99.8
Processing Speed	Superior 122 (116-128)	93rd
Visual Matching	Superior 127 (120-134)	96th
Decision Speed	High Average 111 (103-119)	77th
Short-Term Memory	Very Superior 149 (140-159)	> 99.9
Numbers Reversed	Very Superior 142 (133-150)	99.7
Memory for Words	Very Superior 132 (121-144)	98th

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

GIFTED AND TALENTED EDUCATION PROGRAM ELIGIBILITY ASSESSMENT EXAMPLE 2

[04/13/2005]

NAME:	EM	SCHOOL:	
BIRTH DATE:		GRADE:	1.7
ASSESSMENT DATES:	03/16/2005	TRACK:	
AGE:	6 YEARS 5MONTHS	TEACHER:	
PRIMARY LANGUAGE:	ENGLISH	EXAMINER:	

REASON FOR REFERRAL:
EM was referred for cognitive testing at the request of her parents due to their interest as to whether or not EM would qualify for the Gifted and Talented Education (GATE) Program.

BACKGROUND INFORMATION:
EM is a six year old girl who is enrolled in the first grade at Presentation School. According to EM's mother (Mrs. M), EM does outstanding work at school, and is above her grade level. According to Mrs. M, EM shows strengths in her verbal and reading skills. Mrs. M also reports that EM is imaginative and very inquisitive. Furthermore, Mrs. M reported that EM most enjoys acting, reading, music, sports and time with her friends. Mrs. M also points out that EM's personality is outgoing, cooperative, caring, and that she often takes a leadership role.

EM lives with both of her parents. EM walked and began to talk within the average developmental time frame. EM's last vision and hearing exams were in 2004. Mrs. M reports that EM had a febrile seizure at the age of three. However, she also reports that EM is in good health, and that there are no current health concerns (including vision and hearing).

METHODS OF DATA COLLECTION:
Parent Interview Form
Woodcock Johnson Tests of Cognitive Abilities III
Clinical Observations

BEHAVIOR DURING TESTING:
EM was cooperative and delightful during the evaluation. EM understood all directions, and followed them with considerable enthusiasm. Whenever EM lost focus she would quickly take notice and refocus. Even when the test became quite difficult, EM tried to answer as best she could, and she would often talk herself through it. EM's behavior was appropriate for the testing situation. These test findings are considered to be a valid measure of EM's current cognitive functioning.

COGNITIVE FUNCTIONING:

The test administered to measure EM's cognitive functioning was the Woodcock Johnson III test of Cognitive Abilities (WJIII Cog). The WJIII Cog is a comprehensive test designed to assess general and specific cognitive abilities. It provides information on General Intellectual Ability (GIA) and broad cognitive clusters which include; Verbal Ability, Thinking Ability, and Cognitive Efficiency. The WJIII is comprised of fourteen subtests that measure seven specific cognitive ability areas that make up the broad cognitive clusters.

All tests contain some minor measurement error. Thus, it is best to explain scores within a range which is referred to as a confidence interval. The range of scores representing each confidence interval will be represented below within parenthesis.

EM was assessed using the extended battery of the WJIII Cog. EM's General Intellectual Ability Score (GIA) of 122 (with a 90% confidence band, her true score falls within 118-126) falls within the superior range, and falls at the 93rd percentile.

Verbal Ability

The verbal ability cluster is a measure of verbal comprehension-knowledge ability. Comprehension Knowledge refers to acquired knowledge and the ability to communicate that knowledge. The Verbal Ability cluster includes two subtests: Verbal Comprehension, and General information. EM performed differently on the two tests that measure this broad ability. When asked to identify pictures of different objects, finish analogies, and identify antonyms and synonyms (Verbal Comprehension) EM received a score of 128 (90% confidence band, her true score falls within 118-137) which falls in the superior range, at the 97th percentile. In contrast on the subtest General Information, on which EM was asked to describe common places items are found as well as common functions of items , she received a score of 88 (90% confidence band, her true score falls within 78-97) which falls in the low average range at the 21st percentile.

Thinking Ability

The Thinking Ability cluster represents four different broad abilities; Visual-Spatial Thinking, Long-term Retrieval, Auditory Processing, and Fluid Reasoning. EM received a score of 123 (90% confidence interval, her true score falls between 118-128), which places her in the superior range, at the 94th percentile.

Visual-Spatial thinking refers to EM's ability to manipulate visual images in her mind. This is measured through two subtests, Spatial Relations, and Picture Recognition. EM's score of 118 (90% confidence band her true score falls between 111-125) places her at the 89th percentile, in the high average range.

Long-term Retrieval is a measure of EM's ability to easily store information in her memory, and then access it again for future tasks. Long-term ability is measured by two subtests, Visual-Auditory Learning, and Retrieval Fluency. EM performed in the superior range on this cluster. EM performed differently on the two tests of this broad ability. When asked to recall examples of specific categories (Retrieval Fluency), EM received a score of 136 (90% confidence band her true score would fall between 128-145) which falls in the very superior range, at the 99th percentile. In contrast, on the Visual-Auditory Learning subtest in which she was required to associate novel symbols with words, recall them, and read them in sentence form, she scored a 115 (90% confidence band, her true score falls between 106-124) in the high average range, at the 84th percentile. However it is important to keep in mind that this score,, though lower, is still in the high average range.

Auditory Processing is a measure of EM's ability to discriminate and manipulate sounds effectively. Two subtests that measure Auditory Processing are Sound Blending, and Auditory Attention. EM's score of 132 (90% confidence band her true score falls between 121-142) places her at the 98th percentile in the very superior range.

Fluid Reasoning is a measure of EM's ability to reason, form concepts, and solve problems using novel information or tasks. Fluid reasoning is measured with the subtests, Concept Formation, and Analysis-Synthesis. EM's score of 107 (90% confidence band her true score falls between 102-113) places her at the 69th percentile in the average range.

Cognitive Efficiency
On the Cognitive Efficiency Cluster, EM received a score of 126 (90% confidence band, her true score falls between 120-133) which means that she scored in the superior range, at the 96th percentile. The Cognitive Efficiency cluster measured the speed at which EM performed simple to complicated cognitive tasks. Two broad abilities are measured to determine Cognitive Efficiency. The two broad abilities are Short-Term Memory, and Processing Speed.

Short-Term memory is the measure of EM's ability to take in and hold information momentarily, and then use it within the next few seconds. EM received a score of 102 (90% confidence interval, her true score falls between 93-110) which places her in the 55th percentile, in the average range. The two subtests that measure Short-Term memory are Numbers Reversed and Memory for Words.

Processing Speed is a measure of the speed and efficiency of EM's ability to perform automatic or simple cognitive tasks. Processing Speed includes the subtests Visual Matching, and Decision Speed. EM scored significantly different on the two subtests of this cluster. EM received a score of 125 on the Decision Speed subtest (90% confidence band her true score falls between 118-133), which places her at the 95th percentile in the superior range. This test measured her ability to quickly make conceptual decisions. In comparison, on the Visual Matching subtest, EM scored 147 (90% confidence band, her true score would fall between 141-153) which falls in the very superior range, at the 99.9 percentile. This test required her to quickly find identical numbers. Though these scores are significantly different the difference is not necessarily meaningful since both fall in the superior or above range.

Summary and Recommendations:
EM was enjoyable to work with: she was very enthusiastic and cooperative throughout the assessment.

EM's GIA score of 122 falls in the superior range and does not meet the commonly accepted GATE criteria of 130 or the 98th percentile. EM showed that she is a bright and enthusiastic girl, and I suspect she will continue to do very well in school. Thank you for the opportunity to work with EM.

_____ _____

School Psychology Graduate Student

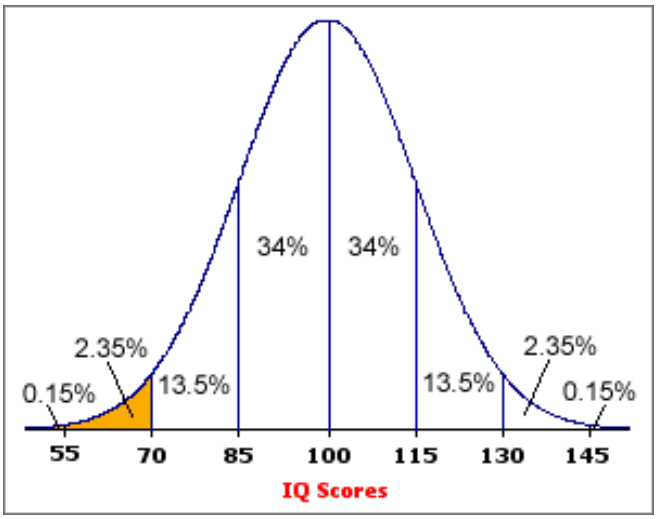
Catherine Christo, Ph.D., NCSP
Supervising School Psychologist

Ability Clusters and Subtests	Standard Score (90% Confidence Range)	Percentile
GENERAL INTELLECTUAL ABILITY	**High Average 122 (118-126)**	**93rd**
VERBAL ABILITY	Average 107 (99-115)	68th
Comprehension-Knowledge	Average 107 (99-115)	68th
Verbal Comprehension	Superior 128 (118-137)	97th
General Information	Low Average 88 (78-97)	21st
THINKING ABILITY	Superior 123 (118-128)	94th
Long-term Retrieval	Superior 130 (121-138)	98th
Visual-Auditory	High Average 115 (106-124)	84th
Retrieval Fluency	Very Superior 136 (128-145)	99th
Visual-Spatial Thinking	High Average 118 (111-125)	89th
Spatial Relations	Average 109 (102-116)	73rd
Picture Recognition	High Average 119 (111-128)	90th
Auditory Processing	Very Superior 132 (121-142)	98th
Sound Blending	Superior 122 (109-135)	93rd
Auditory Attention	Superior 128 (118-139)	97th
Fluid Reasoning	Average 107 (102-113)	69th
Concept Formation	High Average 111 (104-118)	76th
Analysis-Synthesis	Average 103 (96-110)	57th
COGNTIVE EFFICIENCY	Superior 126 (120-133)	96th
Processing Speed	Very Superior 144 (138-149)	99.8
Visual Matching	Very Superior 147 (141-153)	99.9
Decision Speed	High Average 125 (118-133)	95th
Short-term Memory	Average 102 (93-110)	55th
Numbers Reversed	Average 101 (92-110)	53rd
Memory for Words	Average 102 (91-113)	54th

CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

INTELLECTUAL DISABILITY



CALIFORNIA STATE UNIVERSITY
SACRAMENTO

COLLEGE OF EDUCATION
SCHOOL PSYCHOLOGY PROGRAM
School Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079
(916) 278-6252

PSYCHOEDUCATIONAL EVALUATION

[DATE OF REPORT]

NAME:	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATES:	TRACK:
AGE:	TEACHER:
PRIMARY LANGUAGE:	EXAMINER:

REASON FOR REFERRAL

Name was referred for testing by the Student Success Team (SST). It was hoped that this evaluation would aid in the determination of **his/her** special education eligibility. At the time of referral specific concerns included the following: (**From SST data list reasons for referral**). From this referring concern, the following suspected areas of disability were evaluated by this assessment: (**List all areas related to the suspected disability**).

It is important to note that before initiating this evaluation the effects of environmental, cultural, and economic disadvantage on this students' learning was evaluated. From the available data it was concluded (**Report conclusions regarding the effect of these variables on learning and, if necessary, justify the decision to proceed with a special education evaluation**).

PSYCHOEDUCATIONAL PROCEDURES [1, 2, 3, 4]

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) English was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level**?**). These data, combined with the Examiner's basic awareness of this student's cultural and ethnic background (**State how awareness was obtained.**), lead to the conclusion that it was appropriate for this Examiner to conduct this evaluation and to do so in English.

[1] Because **Name**'s primary language is (**Primary language**), the assessment team requested that **his/her** language facility (in both English and (**Primary language**) be assessed. Using the *Language Assessment Scale* (LAS) (**Primary language**), was found to be **Name**'s dominant language (*LAS* English, Level **?**; *LAS* (**Primary language**, Level **?**). Because of these data an interpreter, familiar with the cultural and ethnic background of this student, was used during testing.

[2] This assessment was completed in accordance with a judgment by Federal District Court Judge Robert Peckham (in response to C-71-2270 RFP, Larry P. vs. Riles), which bars the administration of certain tests to this student.

[3] Before beginning this assessment the Examiner ensured that the interpreter had received adequate training to act as an interpreter (**state qualifications**). Experiences within the testing sessions lead the Examiner to conclude that use of this interpreter facilitated attainment of valid test scores.

[4] All psycho-educational procedures were selected and administered so as not to be racially, culturally, or sexually discriminatory, and have been validated for the specific purposes for which they were used.

The following procedures were used to obtain a valid estimate of **Name's** psycho-educational functioning:

[Traditional assessment procedures]

*In analyzing these results it needs to be kept in mind that the tests listed above were generally standardized on (**standardization sample, e.g., monolingual English-speaking children**). Thus, for the purposes of special education placement, the scores are psychometrically invalid. Children with **Name**'s characteristics were not included in the test's standardization samples. The test scores do not necessarily indicate the presence of learning difficulties. However, they do give information regarding **Name**'s present level of functioning in the English-speaking classroom. These scores can be used for baseline and follow-up measures to assess progress in English. Test scores alone should not be used to justify placing **Name** into special education. Alternative assessment procedures used during this assessment included the following:*

[Alternative assessment procedures]

BACKGROUND INFORMATION

Data obtained from **Name**'s cumulative folder indicates (**Report the student's achievement levels, grade-level changes/retentions, discipline records, work habits, prior special program placements, prior referrals, number of schools attended, attendance record, and learning strengths and weaknesses.**)

Program Modifications

Educational interventions already attempted to meet **Name**'s educational needs within a less restrictive environment have included the following: (**e.g., specialist consultations, support services, minimum day, independent study, home teaching, suspension, alternate instructional methods, parent conferences/communication, etc.)**. At this time, these modifications **have/have no**t allowed **Name** to be successful in the general education program.

The following social interventions have been attempted: [**When appropriate list interventions (e.g., counseling) and their duration**. **Describe the outcome of these interventions**].

The following specific behavior interventions have been attempted: (**When appropriate list behavioral interventions and their duration**. **Describe the outcome of these interventions**).

Developmental and Health History

Pregnancy and birth history. During the parent interview **Name**'s mother/father/step-mother/step-father (**Parent's Name**) indicated that (**Describe pregnancy and birth history**). There **are/were no** reports of substance abuse during pregnancy, or oxygen depravation at the time of delivery.

Name was born at term/premature at (**Number of weeks gestation**) weeks gestation. Labor lasted (**Length of labor**) hours. Birth weight was (**Birth weight**). Problems reported to have occurred during the delivery included (**Problems during delivery. In particular note anoxia during birth.**). Birth weight was (**Birth Weight**). One and five minute Apgar scores were (**1 Min. Score**) and (**5 Min. Score**) respectively.

Major developmental milestones. Developmental milestones are reported to have been (**Report milestones**).

Health history. According to (**Data source**), prior to **his/her** diagnosis with (**chronic or acute health problem**), **Name's** health history was (**Describe history**). Recent school screenings (**Date**) suggest (**Vision**) vision and (**hearing**) hearing.

Family history. During the parent interview it was reported that there was no history of family members with learning or behavior difficulties

During the parent interview it was reported that there was a history of other cases of attention deficit disorder and/or learning disabilities within the family.

During the parent interview it was reported that there was a history of other family members with serious psychiatric disorders (e.g., schizophrenia or major depression).

Previous Assessment Findings

Name was previously assessed in (**Date of previous testing**) by (**Examiner**). Results suggested (**Results**).

BEHAVIORAL ASSESSMENT

Adaptive Behavior

Behavior Ratings

Behavioral Observations

Classroom.

Playground.

Home.

Test Taking Behavior.

PSYCHOMETRIC ASSESSMENT

Intellectual Ability

Academic Functioning

Language Functioning

Social and Emotional Functioning

SUMMARY AND EDUCATIONAL IMPLICATIONS

Name is a (**CA**) (**Grade**) grade (**Gender**) who has been assessed to help determine **his/her** eligibility for special education assistance. At the time of referral specific concerns included (**Reasons for Referral**).

Educationally relevant health and developmental findings include (**Discuss relevant findings**).

Environmental, cultural, and/or economic disadvantage have (**Discuss how these variables effect educational performance**).

Name's second language acquisition has affected **his/her** learning (**If appropriate discuss how language acquisition has influenced performance.**

Learning strengths would appear to include....

Learning weakness include....

Name's academic functioning would appear to be affecting **his/her** social functioning in the following ways: (**Describe this relationship**).

From the current battery of tests the following recommendations are made:

1. From this assessment **Name** appears to meet eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(6)]. **He/She** appears to have significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior. These challenges were manifested during the developmental period (which is generally thought to be birth to age 18 years) and adversely affect **his/her** educational performance.

1. **Name** does not appear to meet eligibility criteria as an individual with mental retardation [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030 (h)]. This conclusion is based upon the following assessment finding(s):

    a. **Name** was not found to have significantly below average general intellectual functioning.

    b. **Name** was not found to have significantly below average adaptive behavior.

    c. The effect of the documented disability would not appear to limit **Name**'s ability to benefit from general education program instruction.

    d. **Name**'s learning difficulties appear to be primarily due to environmental disadvantage.

e. **Name**'s learning difficulties appear to be primarily due to cultural disadvantage.

f. **Name**'s learning difficulties appear to be primarily due to economic disadvantage.

g. **Name**'s learning difficulties appear to be primarily due to a lack of English proficiency

h. The available date suggests that a lack of instruction in (**reading and/or math**) plays a primary role in **Name**'s learning difficulties.".

4. Additional areas of suspected disability not addressed in by the current assessment include the following: From this observation the following additional assessments are recommended: (**List additional assessments that are judged required to address all areas of suspected disability, e.g., physical therapy, occupational therapy, recreational therapy, psychotherapy, etc. NOTE: the IEP meeting should not be held until these areas are assessed**).

3. Specific interventions recommended to address **Name**'s anticipated learning needs include the following:

a.

b.

4.

5.

The final decision as to whether or not **Name** meets special education eligibility will be made by the individualized education program team, including assessment personnel, and will take into account all relevant material which is available on **Name**. No single score or product of scores, test or procedure has been used as the sole criterion for the decision of the individualized education program team as to **his/her** eligibility for special education.

_____

Stephen E. Brock, Ph.D., NCSP
Licensed Educational Psychologist

EDUCATION CODE SECTIONS RELATED TO INTELLECTUAL DISABILITY CRITERIA
5 CCR 3030 - Eligibility Criteria

(a) A child shall qualify as an individual with exceptional needs, pursuant to Education Code section 56026, if the results of the assessment as required by Education Code section 56320 demonstrate that the degree of the child's impairment as described in subdivisions (b)(1) through (b)(13) requires special education in one or more of the program options authorized by Education Code section 56361. The decision as to whether or not the assessment results demonstrate that the degree of the child's impairment requires special education shall be made by the IEP team, including personnel in accordance with Education Code section 56341(b). The IEP team shall take into account all the relevant material which is available on the child. No single score or product of scores shall be used as the sole criterion for the decision of the IEP team as to the child's eligibility for special education.

(6) Intellectual disability means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance.

OTHER HEALTH IMPAIRED

PSYCHOEDUCATIONAL EVALUATION

[DATE OF REPORT]

NAME:	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATES:	TRACK:
AGE:	TEACHER:
PRIMARY LANGUAGE:	EXAMINER:

REASON FOR REFERRAL

Name was referred for testing by the (**Referral source**). At the time of referral **Name** had been diagnosed with a **chronic/acute** health problem: (**Medical diagnosis or diagnoses, e.g., heart condition, cancer, leukemia, rheumatic fever, chronic kidney disease, cystic fibrosis, severe asthma, epilepsy, lead poisoning, diabetes, tuberculosis or other communicable infectious diseases, and hematological disorders such as sickle cell anemia and hemophilia**). This evaluation is designed to determine the effect of this condition on **Name**'s school functioning and weather special education assistance is needed.

PSYCHOEDUCATIONAL PROCEDURES

The following procedures were used to obtain a valid estimate of **Name's** psycho-educational functioning:

BACKGROUND INFORMATION

Name is a (**grade**) grade (**gender**) who attends **School**. Data obtained from **his/her** cumulative folder indicates (**Report the student's achievement levels, grade-level changes/retentions, discipline records, work habits, prior referrals, number of schools attended, and learning strengths and weaknesses. Emphasize school attendance history.**). On (**date of medical diagnosis**) **Name** was diagnosed with (**Chronic or acute health problem**). According to (**medical reference book or health care professional**) this condition has the following effect. Current treatments for this condition include (**List treatments**). Undesired complications of these treatments include (**List treatment side effects**).

The educational implications of this medical diagnosis include (**List implications, e.g., fatigue, school absences, changes in physical appearance, amputations, fine or gross motor difficulties, etc.)**.

The social implications of this medical diagnosis include (**List implications, e.g., fatigue, school absences, changes in physical appearance, amputations, fine or gross motor difficulties, etc.)**.

Special considerations necessitated by the outbreaks of infections diseases at school include (**If applicable specify the special actions that would need to be taken if there is an outbreak of an infectious disease that may effect the student and/or the student has an infectious communicable disease that may effect other students**).

Developmental and Health History

Pregnancy and birth history. During the parent interview **Name**'s mother/father/step-mother/step-father (**Parent's Name**) indicated that (**Describe pregnancy and birth history**).

Major developmental milestones. Developmental milestones are reported to have been (**Report milestones**).

Health history. According to (**Data source**), prior to **his/her** diagnosis with (**chronic or acute health problem**), **Name's** health history was (**Describe history**).

Family history.

Program Modifications

Educational interventions already attempted to meet **Name**'s educational needs within a less restrictive environment have included the following: (**e.g., specialist consultations, support services, minimum day, independent study, home teaching, suspension, alternate instructional methods, parent conferences/communication, etc.)**. At this time, these modifications **have/have no**t allowed **Name** to be successful in the general education program.

The following social interventions have been attempted: [**When appropriate list interventions (e.g., counseling) and their duration**. **Describe the outcome of these interventions**].

The following specific behavior interventions have been attempted: (**When appropriate list behavioral interventions and their duration**. **Describe the outcome of these interventions**).

Previous Assessment Findings

Name was previously assessed in (**Date of previous testing**) by (**Examiner**). Results suggested (**Results**).

BEHAVIORAL ASSESSMENT

Adaptive Behavior

Behavior Ratings

Behavioral Observations

Classroom.

Playground.

Home.

Test Taking Behavior. Name is readily accompanied the examiner to the testing room and rapport appeared to be adequate. Rapport was... Level of activity and verbalizations were ... H/Her reaction to failure was ... Encouragement and praise resulted in ... Name's effort was consistent./inconsistent. Results are considered a valid reflection of his/her present level of functioning.

PSYCHOMETRIC ASSESSMENT

Intellectual Ability

Academic Functioning

Basic Psychological Processes

Social and Emotional Functioning

SUMMARY AND EDUCATIONAL IMPLICATIONS

Name is a (**CA**) (**Grade**) grade (**Gender**) who has been assessed to help determine **his/her** eligibility for special education assistance. At the time of referral **Name** had been diagnosed with a **chronic/acute** health problem: (**Medical diagnosis**). This evaluation is designed to determine the effect of this condition on **Name**'s school functioning.

From the available evaluation data it is concluded that **Name**'s health problem has **an/no** affect on **his/her** educational performance. (**Present data that lead to the conclusion regarding the effect of the health problem on educational performance**).

From the current battery of tests the following recommendations are made:

1. From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(9)]. **He/She** has limited **strength, vitality, or alertness, or a heightened alertness to environmental stimuli with respect to the educational environment**, due to a **chronic or acute** health problem: *[NOTE: specify the impairment* **here** *Specific health problems offered in (b)(9) are "asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome.].* This health impairment adversely affects **Name**'s educational performance.

1. **Name** does **not** appear to meet eligibility criteria as an individual with an Other Health Impairment [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030 (f)]. This conclusion is based upon the following assessment finding(s):

    a. There was no data available to document the presence of either a chronic or an acute health problem.

    b. At this time the diagnosed health problem would not appear to significantly adversely affect **Name**'s educational performance. This problem would not appear to limit **Name**'s ability to benefit from general education program instruction.

c. According to (**site medical authority**), the physical disability is temporary in nature as defined by the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3001(af). This means that at the termination of the (**health problem**), **Name** can, without special intervention, reasonably be expected to return to his or her regular education class

d. Environmental, cultural, and/or economic disadvantage were judged to be a primary factor in **Name**'s poor academic **and/or** social functioning.

2. Additional areas of suspected disability not addressed in by the current assessment include the following: . From this observation the following additional assessments are recommended: (**List additional assessments that are judged required to address all areas of suspected disability, e.g., physical therapy, occupational therapy, recreational therapy, psychotherapy, etc.**).

3. The Individualized Education Program team should designate a school liaison with **Name**'s physician. (**If appropriate specify the job title of this individual**).

4. **Name**'s educational performance should be reassessed (**specify a time interval**) to assure that **his/her** health problem does not interfere with educational progress.

5. Specific interventions recommended to address **Name**'s anticipated learning needs include the following:

   a) Individual consultation

   b) **Home/Hospital** instruction

   c) Communication technology such as (**instructional methods that make use of advanced communication technology**).

6.

7.

The final decision as to whether or not **Name** meets special education eligibility will be made by the individualized education program team, including assessment personnel, and will take into account all relevant material which is available on **Name**. No single score or product of scores, test or procedure has been used as the sole criterion for the decision of the individualized education program team as to **his/her** eligibility for special education.

_____

Stephen E. Brock, Ph.D., NCSP
Licensed Educational Psychologist

EDUCATION CODE RELATED TO OTHER HEALTH IMPAIRED CRITERIA

5 CCR 3021.1 - Referral of Pupils Having a Diagnosed Chronic Illness

(a) When a pupil has been medically diagnosed as having a chronic illness or acute health problem, the pupil may be referred to the school district or county office for an assessment to determine the need for special education.

(b) The following information shall be reviewed by the individualized education program team:

(1) The type of chronic illness;
(2) The possible medical side effects and complications of treatment that could affect school functioning;
(3) The educational and social implications of the disease and treatment to include but not limited to the likelihood of fatigue, absences, changes in physical appearance, amputations, or problems with fine and gross motor control, and
(4) Special considerations necessitated by outbreaks of infectious diseases, if applicable.

(c) The individualized education program team shall designate the school's liaison with the pupil's primary health provider.

[Authority cited: Section 56100(a), (i), and (j), Education Code] [Reference: Sections 56300-56303, Education Code; 34 CFR 300.128, 300.220]

5 CCR 3051.17 - Services for Pupils with chronic illnesses or Acute Health Problems

(a) Specialized services may be provided to pupils determined eligible pursuant to Section 3030(f). Such services include but are not limited to:
(1) Individual consultation;
(2) Home or hospital instruction; and
(3) Other instructional methods using advanced communication technology.

(b) For pupils whose medical condition is in remission or in a passive state, the individualized education program team shall specify the frequency for monitoring the pupil's educational progress to assure that the illness does not interfere with the pupil's educational progress.

(c) When a pupil identified pursuant to Section 3030(f) experiences an acute health problem which results in his or her non-attendance at school for more than five consecutive days, upon notification of the classroom teacher or the parent, the school principal or designee shall assure that an individualized education program team is convened to determine the appropriate educational services.

(d) If there is a pattern of sporadic illnesses, the individualized education program team shall convene to consider alternative means for the pupil to demonstrate competencies in the required course of study so that the cumulative number of absences do not prevent educational progress.

[Authority cited: Section 56100(a), (i), Education Code] [Reference: Section 56363(a), Education Code; 34 CFR 300.14(a) (1)]

5 CCR 3030 - Eligibility Criteria

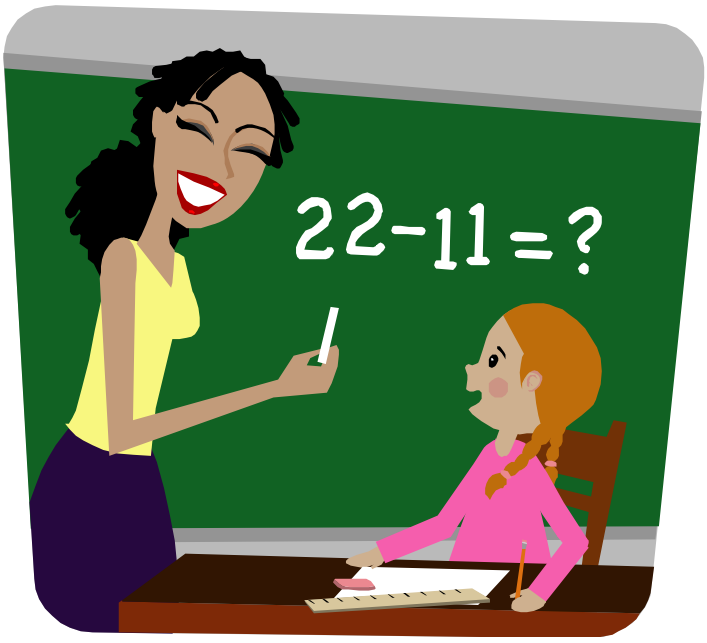
(a) A child shall qualify as an individual with exceptional needs, pursuant to Education Code section 56026, if the results of the assessment as required by Education Code section 56320 demonstrate that the degree of the child's impairment as described in subdivisions (b)(1) through (b)(13) requires special education in one or more of the program options authorized by Education Code section 56361. The decision as to whether or not the assessment results demonstrate that the degree of the child's impairment requires special education shall be made by the IEP team, including personnel in accordance with Education Code section 56341(b). The IEP team shall take into account all the relevant material which is

available on the child. No single score or product of scores shall be used as the sole criterion for the decision of the IEP team as to the child's eligibility for special education.

(9) Other health impairment means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment that:
(A) Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and
(B) Adversely affects a child's educational performance.

5 CCR 3001 - Definitions
In addition to those found in Education Code sections 56020-56033, Public Law 94-142 as amended (20 U.S.C. 1401 et seq.), and Title 34, Code of Federal Regulations, Part 300 and 301, the following definitions are provided:

(af) "Temporary physical disability" means a disability incurred while an individual was in a regular education class and which at the termination of the temporary physical disability, the individual can, without special intervention, reasonably be expected to return to his or her regular education class.


22-11=?

FRAMEWORK FOR IDENTIFICATION OF A LEARNING DISABILITY

The following steps provide a framework for determination of a learning disability. They are adapted from the Operational Definition of LD discussed in EDS 242A. The best reference for this framework is the *Achievement Test Desk Reference* (2006 version), by Flanagan, Ortiz, and Mascolo. Also see Flanagan, Ortiz, Alfonso, Dynda (2006), *Integration of Response to Intervention and Norm-Referenced Tests in Learning Disability Identification: Learning from the Tower of Babel,* in Psychology in the Schools, Vol. 43(7). For reading disability the Users Guide in the new PAL II (contained on disc in the PAL II) has a good framework. This framework would be useful for establishing the presence of a specific learning disability under the option of "a pattern of strengths and weaknesses relevant to the identification of a learning disability."

1. Student is referred because of academic underperformance.
    - Investigate previous instruction and intervention and document within an RTI framework.
    - Review information from teacher and parent.
    - This may be limited in the CCDS but in your field based assessments you should be able to thoroughly review records and talk with the teacher(s).

2. Formal assessment of academic skills
    - Students with learning disabilities have a significant academic deficit. Therefore, the first step in determining the presence of a learning disability is to validate the presence of an academic deficit.
    - Generally this involves performing significantly below peers or expectations for the environment.
    - Information from multiple data sources can be useful in making the decision about the presence of an academic deficit.
    - Standardized academic assessment in areas of concern will provide information about a deficit in relation to a larger norm group.
    - Curriculum based measure of basic skills in math and reading
        - The purpose of this is a quick check on student performance in other academic areas. You may also use something like the WRAT or DAS screener.

3. The next step is to determine if the identified area of academic deficit is due primarily to one of the exclusionary factors. Remember these factors may co-exist with a learning disability.
    - Cultural-linguisitc issues
    - Non-cognitive factors such as motivation, emotional disturbance
    - Mental retardation
    - Sensory impairment or health
    - Insufficient instruction

4. Cognitive assessment to evaluate appropriate areas of development and rule out other disabling conditions
    - Though you may not need a global IQ score you need sufficient information to determine that the student does not have a more pervasive delay that is the primary cause of the academic deficit.
    - Other areas assessed should be selected based on the academic deficit. There are two reasons for this.
        - First you will use that information in a consistency analysis in the next step.
        - Second it will be helpful in intervention planning.

- It is also important to determine that there is an area of cognitive weakness both relative to the general population (normative difference) and relative to the student's overall cognitive profile.
- When a particular cognitive deficit is identified it is important to revisit the exclusionary criteria to make sure that the deficit is not due to any of these.

5. Analysis of cognitive/academic profile.
    - The purpose of this step is to determine if the cognitive/academic pattern is consistent with a learning disability.
    - Is the area of cognitive weakness related to the area of academic weakness.
    - Resources to help you with this include:
    - *Achievement Test Desk Reference*
    - *School Neuropsychology*
    - *WJIII Reports, Strategies and Recommendations*
    - *Essentials of Cross Battery Assessment*
    - *Essentials of Processing Assessment*
    - *Intelligence Tests Desk Reference*
    - For reading or written language: *Users Guide from the PAL II* (loaded on computer in 413A).
    - In this analysis go beyond just your test scores. Use data that you have from teacher report, review of records, etc.

6. The final step in the framework is to determine that the learning disability is affecting performance to a significant degree.
    - This may often be a routine step considering the information obtained above. Also, in CCDS it will be more difficult to do this than in the field.
    - The purpose is to act as a safety valve to assure that the disability is indeed affecting the student's performance to such a magnitude to warrant special education.

LEARNING DISABILITY WORKSHEET

Name _____ Birthdate_____Grade_____
Teacher _____ School _____
Parent(s)_____

Evidence of academic deficit Student performs below the average range in academic area.		
Test	**Standard Score**	**Percentile Rank**

The academic deficit is not due to lack of instruction Describe previous instruction and interventions and outcomes. Attach completed intervention worksheets for tier 1 and/or tier 2 (see attached).

The academic deficit is not due to other developmental causes or to language/cultural factors. Provide data regarding rating scales, cognitive assessments, observations to address the following.	
Factor	**Evidence**
Sensory impairment	
Mental retardation	
Emotional disturbance	
Cultural factors	
Environmental disadvantage	
Limited English proficiency	
Other neurological or genetic disorder	

Cognitive processing deficit related to academic deficit.
The student shows a significant weakness in an area related to the academic deficit (empirically or logically).

Test or Factor	**Standard Score**	**Percentile Rank**

Processing deficit is both normative and ipsative weakness
Describe results of processing assessment worksheet

Identify processing assets
List any processing areas identified as assets for this student

Test or Factor	**Standard Score**	**Percentile Rank**

Summary statement on learning disability
Provide a summary statement as to the diagnosis of learning disability based on the above information and other pertinent information.

DIAGNOSTIC REPORT OUTLINE

Dorothy Marshall - Rev. 1/27/08

Aligned with Flanagan's Operational Definition of LD

I. REASON FOR REFERRAL – Be specific and brief. *Wally Woodcock was referred for evaluation because he failed most classes during his first year in middle school after experiencing success in elementary grades. Mrs. Woodock seeks information about a possible attention disorder or learning disabilities.*

II. BACKGROUND Divide into the following categories.

A. SCHOOL HISTORY – If possible, include schools attended, summaries of report cards, student study team meetings, strengths and weakness in academic subjects, development of referral problem.

LIST INTERVENTIONS GIVEN, including dates and duration if this information is available. Note what core curriculum has been used and if this is a research based curriculum.

- Provide any information about teaching strategies or any statements that would validate that the child had tier 1 instruction that would meet criteria of RTI models (known to be effective, implemented with fidelity).
- Provide as much information on interventions that is relevant to meeting RTI criteria as is possible .i.e. such things as who provided it, how long the student was in it, any information on how progress was measured and what the student's progress was.
- LIST PAST IEP'S IF ANY. *Wally was evaluated for special education services by the Mighty River School District in Sept 2004 but was not placed because a discrepancy between ability and achievement was not found.*

IS CHILD PRESENTLY IN SPECIAL EDUCATION? Describe services.

B. CURRENT SCHOOL PERFORMANCE – How is the child doing in the classroom now? Give comments from current teacher, progress reports, present report card data, review of any work samples you might have. <u>You will relate this to current achievement test findings in section VI A below.</u>

C. FAMILY – Who is the child living with?, Siblings, parental stresses. Is there a significant family history of learning or emotional problems? WHAT LANGUAGES ARE SPOKEN IN THE HOME? The <u>primary</u> language is the child's first language; the <u>dominant</u> language is the one in which the child is most competent at present.

D. HEALTH AND DEVELOPMENT. You can keep this brief; include information from parent questionnaire, and last vision and hearing exams. Are there current health concerns? List psychotropic medications and note whether or not they were taken at the time of assessment.

E. SOCIAL/EMOTIONAL HISTORY. This can be very brief for many referrals. You can include parent descriptions of their child's personality. For those with emotional or behavior issues give history of the problem, any psychiatric diagnoses., current concerns.

III. PRIOR TESTING – Briefly summarize results of the California State tests (STAR) if available. <u>Be sure to include dates and results of previous intelligence tests and any process tests given if they are related to the referring problem.</u> You do not have to include speech assessment, optometrist evaluations, etc. unless you feel they bear directly on the problem. You can either list the cognitive tests and results, or write a brief narrative summary.

IV. OBSERVATIONS OF BEHAVIOR. Include descriptions of test taking behavior, especially anxiety, impulsivity, inattention, or other behavior which may affect test validity. Note if there is a big difference between day 1 and 2 of testing.

V. VALIDITY STATEMENT. DO NOT OMIT THIS. Validity is whether or not the test measures what it is designed to measure, and the essential question is: Was this test a fair measure of what this person can do.? There are two considerations: 1) Is the testee representative of the norm group? and 2)Was his/her test behavior appropriate?. If a child has had a chaotic living situation, or comes from a very economically disadvantaged background, or is a limited English speaker he/she is **not** representative of the norm group and the test is unfair for that person. *Because Lila comes from a disadvantaged background, with little English spoken in the home, current test findings must be treated with caution; they do not reflect future leaning capability but may indicate Lila's current functioning.* OR *Wally is representative of the norm group and his behavior was appropriate. Test results can be considered a valid estimate of current cognitive functioning. OR, Wally's impulsivity, as described above, most probably lowered his intelligence test score which is of limited validity .The overall score may reflect current functioning but should not be used to predict future performance. OR, Lucinda's verbal scores were most probably lowered by limited learning opportunity at home and at school.*

VI. ASSESSMENT MEASURES USED aka METHODS OF DATA COLLECTION. List all tests given and be sure to put the acronym in parentheses after the test. It is best to write out the name of the test again (and it's acronym) when it first appears in your discussion of test results.

VII. DISCUSSION OF TEST FINDINGS

A. ACHIEVEMENT TESTS

1. Describe structure of tests briefly.
2. Measurement Error. There are many ways of describing measurement error which refers to the reliability (consistency) of the test, NOT the validity. Reliability is dependent on the statistics of the test, and does not vary according to the characteristics of the test taker. Measurement error is usually expressed in confidence intervals. You may use a very simple description such as: "*Because of measurement error common to all standardized tests, it is best to think of scores as falling within the ranges given in the parentheses"* or you can use more technical discussions if you prefer.
3. Be selective about how many subtests to give depending on the referring problem, but include at least one test from each academic area (or a CBM probe). This is needed to obtain an achievement strength/weakness profile.
4. Best to report results in a table and summarize briefly in narrative form.
5. Place the following proviso at the bottom (or top) of your achievement test table: **These are national tests of basic skills and do not reflect current performance standards of California classrooms.**
6. Include at least one curriculum based assessment. This can serve as a screener for a presumed area of strength.
7. Qualitative observations of achievement tests and item analyses of pass/fail should be helpful in pinpointing difficulties and suggesting interventions.
8. Relate achievement test findings to school history and current performance. *These test results support Tyrone's teacher's observations of his academic weakness in spelling and writing.*

   Warning: Remember that standardized tests inflate achievement, especially in the early grades and a score in the average range does not necessarily mean there is no academic deficit. *Although Tillie's Reading Composite falls in the average range, the test items*

were not as demanding as first grade expectations at the Elite Academy Elementary School.

B. GLOBAL COGNITIVE TEST

1. Include a BRIEF DESCRIPTION OF THE TEST and its structure (subtests that measure Broad Abilities, Indexes, or Composites.) What are the Broad Abilities supposed to measure. ? You can also think of these Abilities/Indexes as measures of psychological processes.
2. Report Cluster/Index/ Composite Scores. For a diagnostic referral , report Cluster/Index/Composite scores first, before the overall score. This is because you are interested in "peaks and valleys" that might indicate LD as well as overall cognitive ability. You do not have to report the overall score if you don't think it's meaningful. Focus instead on a process oriented profile of cognitive strengths and weaknesses.

   How to report scores? You can describe the clusters and resulting scores in a narrative form, or you can use a table which includes a verbal description of the subtest and clusters. The table can be placed in an appendix or in the body of the text.

   The three Woodcock Clusters are so heterogeneous that you need to report the scores of the Broad Abilities that make up the Clusters. You need to report subtest scores only if they differ significantly from each other.

   The WISC/K-ABC/DAS Index or Cluster Scores are more homogeneous than the Woodcock. If the subtests that make up the various Indexes are not significantly different, you do not need to report them in narrative form. (Scaled score discrepancy of about 3 or less).

   Some authorities (Lichtenberger, et.al, *Essentials of Assessment Report Writing)* believe that it is important to be very specific in describing test results. They also suggest that you always begin with the person, not with the name of the test. Below, is an example of how to report a score if you are using a narrative form with a table in the appendix.

   > *Joe's strength is in his ability to problem solve and see relationships when working with new visual material (Fluid reasoning score 118 (113-123) 88th percentile, above average). Fluid reasoning is especially important for math and science.*

   If you use a table that includes a description of the subtests, broad abilities, clusters or indexes in the body of the text, you do not need to write such a long narrative. You do not need to write about every index or cluster, but point out the strengths and weaknesses. Here is an example of reporting test results with a table in the body of the text:

   > *Joe's strength is in his ability to problem solve and see relationships when working with new visual material, as indicated by his above average score in fluid reasoning, important in math and science.* OR
   >
   > *Short term memory, or the ability to repeat back what has just been said, is a relative weakness for Joe (below average). This can interfere with tracking a lecture or a discussion as well as with long term verbal memory storage.*

4. Your inspection of the high's and low's of the cognitive profile should give you a clue about what further tests to give to evaluate possible processing disorders.

5. REPORT OVERALL (I.Q.) SCORE WITH CAUTION. If there is a very large difference between the various index scores, you may choose not to report the overall score. (The test manuals will give tables to help you) Here is a typical example for use in reporting the overall score when you do not use a table in the text: **As we move away from the discrepancy criteria for LD there should be less and less of a need to report an "IQ".**

   Joe's overall cognitive ability sore of 101 (97-106) is in the average range at the 52nd percentile. This suggests that he should be able to keep up with the average class at his school unless specific processing weaknesses or social-emotional concerns are interfering with learning. OR

   Winifred's scores on the seven abilities measured by this test differ so much from each other that an overall score is not meaningful. Instead, we will examine her strengths and weaknesses to see how they may affect her learning.

6. Summarize and say what the scores mean in terms of the student's learning in the future. What might be easy? What might be difficult? Is the test profile relatively even, indicating that a specific processing disorder may not be present.? Does the low, even profile suggest that the student is a very slow learner, or possibly globally delayed? Do academic and cognitive deficits indicate that specific process tests should be given? You can then say, *Additional learning strengths and weaknesses were evaluated by specific process tests to be described below.*

C. SPECIFIC PROCESS TESTS

1. Give a brief test description in non-technical language.
2. You can use a table in the text, or describe the results in narrative form.
3. As with the cognitive test, it's best to describe the abilities measured rather than just using the name of the test when reporting results. If you use a table your narrative can be shorter.
4. Summarize the process findings. Examine the overall cognitive profile, combining the results of the global and specific cognitive tests. Is there evidence for a processing weakness?
5. Flanagan in her Operational Definition suggests that there must be a normative deficit of 1 SD (a SS of 85 or below) in a cognitive ability/process.. How does the processing weakness relate to the academic deficit? Can the processing weakness shed light on why the student is having problems?

   Harry's cognitive profile reveals a specific processing weakness in working memory. It is difficult for him to hold information in his short term memory, while following additional instructions or operations. On the other hand his ability to think and reason with language, and his ability to remember what he has heard over the short term is very strong. His speed of processing simple information is also strong. Harry's superior fund of information indicates that his long term memory is good. However, Harry's visual spatial processing is relatively weak. This pattern of strength and weakness is often seen in students who have problems, such as Harry, in understanding higher math.

D. SOCIAL/BEHAVIORAL. Requirements will be presented in a separate handout.

VIII. SUMMARY

Note: There are many ways to do a summary and your instructors will have different preferences. The following outlines a short summary.

A. Begin with a sentence containing all identifying information. *Jackson Porter is a 13 year old 8th grade student referred to evaluate possible problems with attention and memory*

B. Brief summary of interventions
C. Disclaimer if tests are considered invalid in some way. (see validity section)
D. Description of test behavior only if it is diagnostic, interfered with testing, or is a strength.
E. One sentence each for global, specific, achievement and social/emotional tests. You do not need to report specific test scores again. Describe the identified processing weakness if any.
F. Integrate the social/behavioral findings, if any, with the test data and history.
G. Be sure to include strengths as well as weaknesses.
H. Look carefully at other reasons that might account for low academic achievement. These are the "exclusionary factors", and will often include poor school attendance, poor motivation, negative attitudes toward school, cultural differences and emotional disturbance.

Jackson's history of cutting classes, his negative attitudes toward school as shown in self ratings, his acceptable scores in tests of basic skills all suggest that his academic problems are not primarily caused by specific learning disabilities.

I. Address the specific referral question.
J. Special education eligibility if appropriate. This is very tricky as current policies are all over the place. **For possible identification as a learning disabled student,** you do not need to focus on a discrepancy between I.Q. and achievement. The main points to consider here are: Lack of progress in research based interventions, academic deficits reported in the classroom and seen in standardized achievement tests, an uneven cognitive profile with a processing weakness related to the academic deficit, and consideration of the exclusionary factors. (From Flanagan model). If your student fits this pattern and referral for additional services is appropriate, you could say:

Harry's history of academic struggles in math classes in spite of considerable school based interventions, his low achievement test scores in math, his uneven cognitive profile with many strengths and specific weaknesses in spatial ability and working memory, all suggest that he may be eligible for special education services. These test findings can be shared with the Resource Specialist at Harry's home school.

IX. RECOMMENDATIONS

A. Group recommendations by problem areas, or home/school.
B. Be careful with recommendations for school; make sure that they are specific and are worded so as to respect what the teacher is already doing with the child.
C. Make sure recommendations are age and grade appropriate.
D. No more than 5 recommendations for each area
E. Be cautious…use qualifying words. *could benefit from, parents may wish to, may be helpful.*
F. Good print sources for recommendations:
   1. Mather, N., & Jaffe, L. (2002). *Woodcock-Johnson III, reports, recommendations and strategies.* New York: Wiley..
   2. Shaywitz, S. (2004). *Overcoming dyslexia.* New York: Knopf.
G. You can go to Intervention Central.org for many suggestions. Choose carefully.

READING DISABILITY

DYSLEXIA DIAGNOSTIC EVALUATION HEALTH, FAMILY, DEVELOPMENTAL, & BEHAVIORAL HISTORY INTERVIEW FORM

Child's Name: _____ Birth date: _____
School: _____ Grade: _____
Parent(s): _____ E-mail: _____
Home phone: _____ Alt. Phone: _____
Languages spoken in the home: _____
Siblings and their ages: _____
Other adults living in the home: _____

Number of books in the home (circle):	None	Several (< 20)	Many (20+)	Hundreds
Times per week the child is read to (circle):	Never	1-2 days	3-5 days	6-7 days

Referring concern: _____
_____
_____
_____
_____
_____

At what age and/or grade did the referring concerns first emerge? _____

Health History (Perinatal Factors)

35. General obstetric status (circle one): Optimal Adequate Poor
    Describe: _____
    _____
    _____
    _____

36. Alcohol exposure during pregnancy (circle): YES NO If YES answer the following:
    a. How often did mother drink? Every day Once a week Rarely
    b. How much did mother drink? Just a little One drink Several drinks
    c. When during pregnancy did mother drink? 1st trimester 2nd Trimester 3rd trimester

37. Drug exposure during pregnancy (circle): YES NO If YES answer the following:
    a. What drugs were taken? List: _____
    _____
    _____
    _____
    b. When during pregnancy were drugs taken? 1st trimester 2nd Trimester 3rd trimester

Health History (Perinatal Factors, continued)

38. Complications during delivery (circle)? YES NO If YES describe:
Describe: _____
_____
_____
_____

39. Birth weight (list): _____lbs. _____oz.

Health History (Infancy and childhood)

40. Illnesses
(Describe/List when illness occurred)? _____
_____
_____

41. Chronic ear infections YES NO If YES answer the following:
    a. When did they occur? _____ months to _____ months
    b. How often did they occur? _____ per month (or) _____ per year
    c. Were tubes placed? YES NO When?_____
    d. Was there hearing loss? YES NO If YES describe
_____
_____

42. Other Medical Diagnoses/Issues (circle):
High fevers Head trauma
Fetal alcohol syndrome Epilepsy
Lead poisoning Mental retardation
Immune dysfunction Thyroid problems
Arthritis Cerebral palsy
Allergy history Gastrointestinal symptoms
Hydrocephalus Prolong hospitalizations
Other (list): _____
_____
_____

43. Suspected vision loss YES NO If YES describe reasons for concern: _____
_____
_____

44. Suspected hearing loss YES NO If YES describe reasons for concern: _____
_____
_____

45. Vision Screening (list): Date: _____ Near 20/___ Far 20/___

46. Hearing Screening (list): Date: _____ Result: _____

Family History

47. Parent with dyslexia (circle)? YES NO

48. Parent with learning disability(ies; circle)? YES NO

49. Family members with dyslexia (circle)? YES NO If YES answer the following:
    a. Relationship to child (list): _____
    b. An identical twin? YES NO

50. Family members with learning disability (ies; circle)? YES NO If YES answer the following:
    a. Relationship to child (list): _____
    b. An identical twin? YES NO

17. Health/developmental problems among family members? Describe: _____

18. Maternal educational attainment (circle)?
    No High School Some High School
    High School Grad. Some College
    College Grad. Some Graduate School
    Degree(s, List): _____

19. Paternal educational attainment (circle)?
    No High School Some High School
    High School Grad. Some College
    College Grad. Some Graduate School
    Degree(s, List): _____

Developmental History

20. Age major milestones were obtained (list)?
    First word _____months
    Sentences _____months
    Stands alone _____months
    First steps _____months
    Walks alone _____months

Diagnostic History

21. Speech/Articulation disorders YES NO
    a. Type(s) of disorder (list): _____
    b. Type(s) of treatment (list): _____
    c. Duration of treatment (list): _____

22. Language disorders YES NO
    a. Type(s) of disorder (list): _____
    b. Type(s) of treatment (list): _____
    c. Duration of treatment (list): _____

23. Central Auditory Processing difficulties YES NO
    a. Type(s) of treatment (list): _____
    b. Duration of treatment (list): _____

24. AD/HD YES NO
    a. Type(s) of disorder (list): _____
    b. Type(s) of treatment (list): _____
    c. Duration of treatment (list): _____

25. Other diagnoses (list) _____

School History

26. Number of schools attended (list) _____

27. School attendance history (describe) _____

28. Prior special education services? YES NO

29. Educational interventions (describe) _____

Reading Related Behavioral History[1]

30. Infant (birth to 18 months)

Focused eyes on an object	YES	NO
Reached for and held books	YES	NO
Held head steady and sat without support	YES	NO
Pointed with one finger at an object	YES	NO
Turned board pages, several at a time	YES	NO
Looked at pictures	YES	NO
Vocalized at, patted, and pointed to pages/pictures	YES	NO
Turned books right side up	YES	NO

Gave books to an adult to read	YES	NO
31. Toddler (18 months to 3 years)		
Turned board pages, one at a time	YES	NO
Carried books	YES	NO
Named familiar pictures	YES	NO
Filled in words in familiar stories	YES	NO
Pretended to read to others	YES	NO
Recited parts of well-known stories	YES	NO
Learned to handle paper pages	YES	NO
Found favorite pictures in books	YES	NO
Related text to pictures	YES	NO
Protested when words in a familiar story were read wrong	YES	NO
Read familiar books to self	YES	NO
Named family member pictures	YES	NO
Recognized familiar signs (e.g., fast food restaurants)	YES	NO
32. Preschool (3 to 5 years)		
Was able to handle/manipulate books	YES	NO
Turned paper pages, one at a time	YES	NO
Listened to longer stories	YES	NO
Was able to retell a familiar story	YES	NO
Understood what text is	YES	NO
Moved finger along text	YES	NO
"Wrote" name	YES	NO
Was able to pronounce words without problem (i.e., no baby talk)	YES	NO
Had no difficulty finding the right word in speech	YES	NO
Was able to rhyme words	YES	NO
Learned common nursery rhymes (e.g., "Jack and Jill")	YES	NO
Learned letters in own name	YES	NO
Was learning numbers/letters	YES	NO
Noticed if parents skipped a word while reading	YES	NO
Was able to name shapes and colors	YES	NO
Was able to recognize own name in print	YES	NO
Was able to repeat the alphabet without the "ABC" song	YES	NO
33. Kindergarten and First Grade (6 to 7 years)		
Learned letter sound associations	YES	NO
Did not confuse basic words (e.g., run and eat)	YES	NO
Learned that words come apart (e.g., "batboy" = "bat" and "boy")	YES	NO
Learned that words come apart (e.g., "bat" = "b" "aaa" "t")	YES	NO
Reading errors were phonetic (e.g., "bat"="bait," not "bat"="goat")	YES	NO
Read common one-syllable words (e.g., mat, cat, sat)	YES	NO
Enjoyed reading (i.e., no complaints about it being hard)	YES	NO
34. Second Grade and Beyond (8 years and older)		
Was able to pronounce long, unfamiliar, complicated words	YES	NO
Speech was fluent (e.g., no pauses, hesitations, or a lot of "um's")	YES	NO
Language was precise (e.g., avoids "stuff" instead of object names)	YES	NO
Was able to "find" words easily when speaking	YES	NO
Needed little time to summon an oral response	YES	NO
Was able to quickly remember dates, names, phone numbers, etc.	YES	NO

Was able to read/sound out new and unfamiliar words	YES	NO
Could describe how to read new and unfamiliar words	YES	NO
Was able to read "function" words (e.g., "that" "an" "in")	YES	NO
Was able to read/sound out multi-syllable words	YES	NO
Enjoyed reading and has no fear of reading out loud	YES	NO
Oral reading became fluent (not slow and tiring)	YES	NO
Oral reading included inflections and sounds	YES	NO
Did well on multiple choice tests	YES	NO
Ability to read single words was as strong as passage comprehension	YES	NO
Finished tests on time	YES	NO
Spelling errors were close to true spelling	YES	NO
Was able to read math word problems	YES	NO
Was able to finish homework in a timely fashion	YES	NO
Read for pleasure	YES	NO
Was able to learn a foreign language	YES	NO
Did not substitute words unable to pronounce with words that had the same meaning (e.g., "car" for "automobile")	YES	NO

[1]Adapted from Coordinated Campaign for Learning Disabilities (1997), Reach Out and Read (n.d.), Shaywitz (2004a, 2004b), and The Help Group (n.d.).

FRAMEWORK FOR ELIGIBILITY AS A STUDENT WITH A READING DISABILITY

Step 1	Student is referred for consideration of eligibility because of reading difficulty.
	• Investigate previous instruction and intervention, and document within an RTI framework. • Review information from teacher and parent.
Step 2	Formal assessment of reading skills to determine that student is not achieving adequately for his age or grade level standards.
	• Students with learning disabilities have a significant academic deficit. Therefore, the first step in determining the presence of a reading disability that qualifies a student as needing special education services is to determine the presence of significantly discrepant reading skill. • Generally this involves performing significantly below peers or expectations for the environment. • Information from multiple data sources can be useful in making the decision about the presence of an academic deficit. • Standardized academic assessment in areas of concern will provide information about a deficit in relation to a larger norm group. • Also review performance in other academic areas with record review or brief academic screener.
Step 3	Determine if the reading deficit is due *primarily* to one of the exclusionary factors.
	This step requires sufficient assessment or record review to determine whether the reading problem is due primarily to: • Cultural-linguistic issues • Non-cognitive factors such as motivation, emotional disturbance • Mental retardation • Sensory impairment or health • Insufficient instruction
Step 4	Cognitive assessment to evaluate appropriate areas of development and rule out other disabling conditions.
	• Though you may not need a global IQ score you need sufficient information to determine that the student does not have a more pervasive delay that is the primary cause of the reading problem. • It is important to determine that there is an area of cognitive weakness both relative to the general population (normative difference) and relative to the student's overall cognitive profile. • For a reading disability it will be important to evaluate cognitive processes linked to reading: phonological processing, rapid naming, working memory, language. • When a particular cognitive deficit is identified it is important to revisit the exclusionary criteria to make sure that the deficit is not due to any of these criteria.
Step 5	Analysis of cognitive academic profile.
	• The analysis of the cognitive/academic profile serves to determine if the pattern of strengths and weaknesses is consistent with a reading disability.

	• A student with dyslexia will demonstrate cognitive processing weaknesses in those areas related to reading, but will not show an overall language delay.
Step 6	Determination that the reading disability is affecting the student's performance to a significant degree and the student's needs cannot be met without special education.
	• The purpose of this final step is to assure that the impact of reading disability is of such magnitude that the student needs special education in accordance with *IDEA 2004*.

SUGGESTED READING DISABILITIES PROTOCOL AND REPORTING RECOMMENDATIONS

Catherine Christo, Ph.D.

A suggested protocol for testing of reading disabilities includes:

1. A general cognitive measure such as WJ-III
2. General achievement measure such as WJ-III tests of achievement
3. Comprehensive Test of Phonological Processing
4. Test of Word Reading Efficiency
5. Process Assessment of the Learner II
6. Gray Oral Reading Test-3
7. A language comprehension (Gc in global cognitive tests is a possibility) measure

The general use of these tests may be discussed in your report as follows:

*The purpose of these tests is to provide a complete picture of the reading process at the **subword, word, text** and **language comprehension** levels. **Subword** level refers to those underlying cognitive processes that are known to be linked to reading success or difficulty and to literacy issues that have to do with letters as opposed to words. The cognitive processes typically of greatest interest include phonological processing and rapid naming. **Word** level assessments are those tests that are designed to look at a student's abilities to process isolated words. At the **text** level, fluency and automaticy are critical. In assessing text level skills, tests are measuring these things as well as comprehension. **Language comprehension** is addressed because it is important to determine if the reading issue is word specific (dyslexia) or if it involves language processing disabilities.*

In your report the specific discussion of individual tests and subtests that assess subword level processes may include the following:

- *On the CTOPP, ... was able to blend sounds and perform simple sound segmentation tasks.*
- Discuss CTOPP composites of phonological awareness, phonological memory and rapid naming
- The Process Assessment of the Learner (PAL) also provides tests of rapid naming and phonological processing. However, it is scored in a grosser scale with deciles and levels of risk/proficiency.
- You may also include here any other verbal memory or auditory processing measures (e.g. Ga tests)
- The WJ-III has speed measures as well (retrieval fluency, rapid picture naming) which also form a clinical cluster that looks at automaticity.
- The WJ-III Predicted Reading Achievement score provides a score that is a composite of those broad abilities most strongly predictive of reading. This composite can be compared to General Ability for help in determining if the student has weakness in those processes most connected to reading.

The specific discussion of individual tests and subtests that assess word level processes may include the following:

- *The TOWRE provides information on **word**-related reading skills. Skilled reading requires the ability to quickly recognize familiar words and to quickly decode new words. The two subtests of the TOWRE provide a timed measure of real and nonsense word reading: Sight Word and Phonemic Decoding Efficiency scores.*
- You may also include an untimed decoding task such as WJ-III Word Attack (e.g. *Sara's ability to apply sound/ symbol rules to read nonsense words without time preasures...*), Other untimed word reading tests are Letter-Word Identification on WJ-III or Basic Reading on WIAT.

- Can also talk about spelling subtests (e.g. *Most of Sara's spelling errors result in phonetically decodable words. Her confusions are typical of younger children (e.g. using "g" for the "sh" sound in measured*).).
- Other information that may be included here includes any more discrete tests such as Decoding Skills Test.
- A new area of interest is orthographic processing, which reflects how well the student processes the individual letters in words. Currently, only the Process Assessment of the Learner (PAL) has any orthographic processing tests.

The specific discussion of individual tests and subtests that assess text level processes may include the following:

- The GORT-3 provides a measure rate and accuracy when reading a short passage and a measure of comprehension of the material read.
- Other reading batteries have a comprehension subtest as well. Some are cloze procedures and others are short passage comprehension. WJ-III has reading vocabulary tests. The value of the GORT is its measure of rate.
- WJ-III reading fluency test is also a good rate measure and provides a measure of silent reading speed as opposed to GORT, which measures oral reading.

The specific discussion of individual tests and subtests that assess language comprehension level processes may include the following:

- There are many different language comprehension tests. Most measures of Gc provide a sufficient measure of language.
- Many other tests have a listening comprehension subtest or you may find this information in a report from the speech therapist.

In the clinic, you may not have time to do all the above, so it is important to choose assessments that you feel will most adequately address the issues for the student you are assessing. For example, you may know from report that language is not an issue.

READING DISABILITY ASSESSMENT REPORT LANGUAGE SAMPLE 1

Psycho-educational Evaluation

Client: Joey Jones **Birthdate**: July 7, 1997

Parents: Cindy Jones **Date of Report**: May 9, 2006

Address:

Reason for Referral:
Joey was evaluated at the request of his parents. His parents are concerned about Joey's progress in learning to read and wanted (a) information regarding the reasons for his difficulties and (b) information that would be useful in educational planning.

Background Information:
Joey lives with his parents and older siblings. He is in second grade. Joey has no health issues and his vision and hearing exams are current. Mrs. Jones reports that Joey met developmental milestones within the normal range and is athletically advanced. Joey has been a healthy child and has passed annual vision and hearing exams. In regards to family history, Ms. Jones reports that her husband had problems learning to read.

Joey attends Holy Trinity School and has had reading support primarily through a private tutor. He receives tutoring two times per week for up to 2 hours each visit. Joey continues to be working well below grade expectations. His teacher reports that he is the lowest reading child in her class of 30 students. Joey was retained in kindergarten due to concerns about his reading development. He is described by both his mother and his teacher as a friendly boy with many friends. His mother and teacher also report however, that Joey's reading problems are causing him to feel badly about school and are impacting his confidence in himself.

Previous Testing:
A report dated November 7, 2005 from PSYCH, school psychologist, indicates that Joey performed within the average range on the WISC-IV. The following tests were also administered: Wechsler Individual Achievement Test-II, Test of Visual Perceptual Skills-Revised, Test of Auditory Processing Skills-Revised, Beery Test of Visual Motor Integration and Comprehensive Test of Phonological Processing. Mr. PSYCH reports that, though Joey showed a discrepancy between ability and achievement, there was no evidence of a processing disorder. Therefore, the IEP team did not consider Joey as eligible for special education.

Joey scored below average on the alternative rapid naming composite of the CTOPP (primarily due to difficulties with rapid object naming which Mr. PSYCH noted may have depressed his score). The variation in Joey's performance on academic achievement tests is noteworthy. Joey displayed listening comprehension skills within the superior range (SS=121) and reading comprehension skills in the low average range (SS=86). Joey also showed a marked difference between his calculation skills (SS=100) and his math reasoning (SS=124). Such significant differences in application and basic skills are often seen in students with specific learning disabilities.

Behavior During Testing:
Joey was evaluated during one session of approximately two hours. He was friendly and enjoyed engaging in conversation with the examiner. Joey put forth good effort on all tasks presented even when they became difficult for him. He expressed his reluctance to perform some reading tasks but nevertheless willingly completed them with good effort.

The test results can be considered a valid indication of Joey's current level of functioning.

Intervention History

Joey was retained in kindergarten due to problems with reading. He has had a tutor for the past two years who works with him two times per week for one to two hours each time. His tutor, XXX, is a resource specialist teacher who has consistently used research based interventions and an individualized program with Joey. Currently they are working with Read Naturally, the Fry Word List and Explode the Code. They also work on written language activities. In addition, Joey's mother reads with him on a regular basis. Joey has made steady progress in these programs and is currently in level 2.0 of Read Naturally.

Assessment Results:

Selected assessments were completed in order to address the primary referral questions: What is Joey's current reading competence? Does he need special education support or support beyond what can be offered in his current school placement? What are some recommendations for helping him with reading? Because recent test results are available for Joey this assessment focused on a more in-depth evaluation of Joey's reading and related processes. Thus the purpose of this assessment was to supplement the evaluation already completed with Joey.

Portions of the following tests were administered:
Woodcock Johnson Tests of Cognitive Abilities (WJIII)
Process Assessment of the Learner (PAL)
Gray Oral Reading Test (GORT4)
Wide Range Assessment of Memory and Learning II (WRAML II)

The individual scores for these tests are presented at the end of this report.

Memory.

Previous testing indicated average visual memory and generally average verbal and phonological memory.

Short term memory: Joey performed within the average range on previous testing measuring working memory and on a variety of auditory and visual short term memory tasks such as number and word memory.

*Long-term storage and retrieval***.** Long-term storage and retrieval refers to those processes that involve learning something and recalling it after learning other information or recalling previously learned material. Joey had difficulty with rapid retrieval of simple information such as names of foods (WJIII Retrieval Fluency SS=81). He also had difficulty with an associative memory task measuring his ability to link symbols with non-meaningful labels (WRAML Sound Symbol). He performed at the 17th percentile on this task. In contrast when required to learn and remember rebuses presented in sentence like format, Joey performed within the average range. It is likely that Joey's strong language skills enabled him to profit from semantic and syntactic cues in recalling the labels for the rebuses.

Rapid Naming; Rapid naming involves the ability to quickly name a series of over-learned items such as numbers or letters. It is tested under timed conditions. Thus it requires the student to view the stimulus, quickly retrieve its label, say it and move on to the next item. Joey's naming speed was previously measured through subtests of the Comprehensive Test of Phonological Processing. He performed within the average range when naming letters, digits and colors and below average when naming objects. Joey also had great difficulty with a rapid picture naming task on the WJIII performing at the 3rd percentile. In addition, he performed in the below average range on a speeded matching task that required him to rapidly retrieve and compare numbers. In contrast, Joey performed above average when finding semantically connected picture

objects. On the Process Assessment of the Learner, Joey was able to name letters and numbers at a speed within the average range; however, when required to rapidly shift between naming words and numbers he performed below the 20th percentile.

Phonological Memeory. Phonological memory refers to the ability to use phonological codes for short term memory and recall. On the previous administration of the CTOPP Joey performed within the average range.

Reading:

In order to understand Joey's reading skills it is useful to look at the various levels of the reading process. **Subword** level refers to those underlying cognitive processes that are known to be linked to reading success or difficulty. *Phonological processing* has been described as an area of core deficit for children with reading disabilities. Phonological processing refers to the ability to manipulate the sounds of language. It is assessed by tasks such as rhyming, recognizing similar sounds in words or removing sounds and reconstructing the word. Joey performed within the average range on the phonological processing tasks previously administered with the CTOPP.

Another cognitive process associated with reading disabilities is the ability to quickly name letters, digits or pictures of common objects. As noted above, Joey exhibits some deficits in rapid naming.

Joey's performance on orthographic coding tasks reflects his ability to store information about the letters in words. Joey performed at the low end of the average range on tasks requiring him to recognize letters and letter groups seen in words. Joey's alphabet writing speed was also assessed. His ability to quickly write the letters of the alphabet was within the average range for his grade.

Previous testing provided information on Joey's **word-**related reading skills. Skilled reading requires the ability to recognize words that one has seen before and to decode new words. Word reading is assessed in both timed and untimed conditions with real and novel words. Joey performed within the average range on a previous test of nonsense word reading and below average on a test of real word reading in untimed conditions. Joey's orthographic processing, or ability to distinguish real words from incorrectly spelled but phonetically correct choices, was below the 10th percentile.

Text level skills were evaluated with the Gray Oral Reading Test (GORT). Joey's reading rate places him at the 4th percentile and his accuracy is at the 6th percentile using grade level norms. His reading comprehension, as measured by his ability to answer questions about the passages he read, was at the 16th percentile.

In contrast to his difficulties with written language, Joey's **oral language** skills are within the high average to superior range. In addition, he displays good vocabulary in conversation and his teacher reports that he contributes easily to class discussions.

Summary:

The purpose of this evaluation was to explore Joey's learning in order to provide insights into his difficulties in learning to read and information useful in planning educational interventions. Because he has a family history of reading problems, early intervention to address any difficulties is appropriate.

Joey's phonological processing appears to be within the average range. He displayed a mixed profile on tests of rapid naming and rapid retrieval. When comparing his performance across batteries, he appears to have significant problems with rapid retrieval of certain types of named information. Phonological processing and rapid naming are the two core deficit areas most commonly linked with dyslexia. Joey's difficulties with rapid retrieval are likely impacting his learning to read. Speed in retrieving sounds and

words is essential to increasing reading skill. Because Joey is not able to quickly retrieve word information he is not able to create a storehouse of automatically recognized words. While automatic recognition of a word may occur for average readers after one to four exposures to the word it will take Joey many more exposures to automatically recognize a word. In addition, because he will need to expend considerable mental energy into decoding each word rather than thinking about what he is reading, his comprehension is affected. Joey displayed some very good decoding strategies, which are to be encouraged. However, his use of these strategies indicates that he is lacking automatic recognition of words that are automatic for most children his age.

Joey has had considerable intervention and still is reading below expectations. For a child who is at-risk for reading disabilities and who has had consistent, research based interventions and possesses strong verbal skills, this is of concern. He seems to be responding to interventions; his tutor reports consistent progress with the current program and she adjusts it as necessary to meet his needs.

Joey was assessed by the XXX Unified School District and found to not be eligible for special education due to the lack of a processing disorder, though he did display a significant discrepancy between his ability and achievement in reading. Current testing indicates that Joey exhibits rapid retrieval deficits indicating a processing disorder related to long term memory. Joey's parents plan to provide him with continuing intervention support over the summer. It is possible that this support may increase his reading skills to a sufficient level that he will not need special education services in the fall. His reading skills should be re-evaluated at that point to determine if he needs special education services or if he can be provided with sufficient support in general education.

Recommendations

1. Interventions should provide explicit instruction in the foundational skills of reading and incorporate a systematic, sequential approach to the presentation of new skills.
2. In addition, it is important that Joey be evaluated for mastery of each skill before new concepts are introduced. Because he demonstrates speed related retrieval deficits it will require more trials for him to make retrieval of words and word parts automatic.
3. Joey should also receive instruction in the five areas identified by the National Reading Panel: phonological awareness, phonics, fluency, vocabulary, and text comprehension. Though they do not necessarily need to be addressed in the same program, it is important to assure that all areas are addressed.
4. Because Joey's reading problems rest in the difficulty of creating a storehouse of automatically recognized words a program focusing on letter patterns will help him to begin recognizing chunks of words. As he gains familiarity with letter combinations he will be able to apply this to longer words.
5. Programs that incorporate a multi- modality approach such as Orton-Gillingham would also be useful and would provide a further memory path for linking sounds and letters. If other types of programs are used it is important to link decoding with encoding, so that Joey is not only learning to read words but is practicing writing and spelling these same words.
6. During the summer, Joey could benefit from an intensive program to boost his reading as well as assure that he does not lose the gains he has made. His current program consisting of a code emphasis program (*Explode the Code)* and a fluency program (*Read Naturally)* is a good blend for him. It is also important to assure that he is doing writing with the same words and letter patterns he is learning. Should this continue to be his program for the summer, Joey would benefit from instruction 4-5 days per week. Another possible program is *Phono-Graphix.*
7. It is also important to assure that Joey has exposure to text written at a level above his current reading level so that he continues to develop his vocabulary and comprehension skills. Therefore, nightly reading with a parent will be an important ongoing strategy.

8. Teacher and parent reports indicate that Joey is very anxious about his reading. Therefore, it is important that he experience a systematic program that will start at his success level and build upon that (*Read Naturally* is a good choice for monitoring progress and providing Joey with clear indication of his progress). Other programs such as *Great Leaps* also include progress monitoring methods.
9. Joey will need accommodations as a result of his reading problems. Appropriate accommodations that should e considered for him include extra time on tests, support with word problems in math and oral test taking in subject matter tests. Without these accommodations it may be difficult to accurately assess Joey's learning in the identified areas.
10. It is also important to address the emotional ramifications for Joey of experiencing the difficulties he has in learning to read despite considerable time and effort. Two resources to help parents in talking with children about learning differences are www.ldonline.org, and www.**allkinds**of**minds**.org.

Catherine Christo, Ph.D., NCSP
Licensed Educational Psychologist

Scores for Joey Jones
Date of Assessment: 4/03/2006

WOODCOCK JOHNSON III TESTS OF COGNITIVE ABILITY

Subtest	Standard Score (Range)	Percentile
Visual-Auditory Learning	96 (89-104)	40th
Visual Matching	84 (78-89)	14th
Retrieval Fluency	81 (70-93)	11th
Decision Speed	117 (108-126)	87th
Rapid Picture Naming	71 (68-73)	3rd
Cluster	Standard Score (Range)	Percentile
Long-Term Retrieval	89 (81-97)	24th
Processing Speed	97 (92-102)	41st
Cognitive Fluency	82 (78-87)	12th

GRAY ORAL READING TEST

Composite	Standard Score	Percentile
Rate	4	2nd
Accuracy	9	6th
Fluency	5	5th
Comprehension	7	16th

PROCESS ASSESSMENT OF THE LEARNER

Subtest	Decile Score
Receptive Coding	<40th
RAN Letters	<50th
RAN Words	<40
RAN Digits	<50
RAN Words and Digits	<20
Word Choice	<10
Fingertip Writing	<10
Sentence Sense	<10

WIDE RANGE ASSESSMENT OF MEMORY AND LEARNING

Sound Symbol 17th percentile

READING DISABILITY ASSESSMENT REPORT LANGUAGE SAMPLE 2

Psycho-educational Evaluation

Client: Maggie Smith **Birthdate**: January 12, 1998

Parents: **Date of Report**: August 26, 2008

Address:

Reason for Referral:
This evaluation was done as a result of an agreement between Maggie's parents, and the XXX Unified School District regarding the need for an independent evaluation. The purpose of the evaluation is to provide further information regarding Maggie's reading.

Background Information:
Maggie is currently enrolled in XXX Elementary and will be entering 5th grade in fall, 2009. More detailed health history and background information are available in the report of 3/8/07. Developmental milestones were reached within an average range and her health history is generally unremarkable with the exception of kidney reflux disease. She has passed school vision and hearing screenings. However, she does have glasses for near vision.

Ms. Smith reports that Maggie's father and other members of his family have dyslexia. Maggie has three older siblings only one of whom still lives at home.

Educational History

Detailed information regarding Maggie's educational history is available in the multi-disciplinary report of 3/08/07. Only a summary will be provided in this report. Maggie received literacy support services beginning in first grade and continuing through the most recent academic year. A variety of interventions have been implemented including specific remedial programs and classroom modifications. Student support team meetings have been held to address concerns and retention has been considered. In contrast, Maggie has performed well on English/ Language Arts standards test, performing in the proficient level in 2nd, 3rd and 4th grade. Thus, it seems that Maggie has demonstrated behaviors that have caused her teachers and parents to have concerns about her reading development (for example, poor spelling, lack of phonics knowledge) but that on standardized tests focusing on word knowledge and comprehension she appears to perform at grade level.

Mrs. Smith reports that Maggie appears stronger in oral language than in reading and that her "general language skills seem pretty good". She notes that Maggie will often not understand word problems in math when she reads them but then will understand them when read out loud to her. She also notes that, though Maggie was strong in math in previous grades, she appears to be struggling with division and multiplication. She reports that it takes Maggie a long time to complete tests. Mrs. Smith also notes that homework takes much longer for Maggie than for other students. Maggie is hard working and committed but the amount of time it takes her to complete homework is becoming problematic.

Previous Evaluations
Multidisciplinary Evaluation Team 3/07
Formal assessment was completed in March of 2007 by a Multi-Disciplinary Evaluation Team in XXX Unified School District. Academic testing placed Maggie within the low average to average range in

comparison to national norms in the areas of reading and written language. Math scores ranged from high average to superior. Maggie demonstrated strengths in math reasoning.

On cognitive assessments Maggie performed in the high average range on tests of verbal reasoning, the average range on perceptual reasoning and working memory tasks and the below average range on measures of processing speed. Maggie showed high average auditory reasoning and comprehension, visual perceptual skills and phonological awareness.

Maggie also was reported as exhibiting age-appropriate social-emotional skills. The team conclusion noted that Maggie did not exhibit a significant discrepancy between ability and achievement at the time of testing and recommended further monitoring of her progress by the SST team and a variety of home and school strategies.

Diagnostic Testing for Dyslexia 11/07
Leslie Snap performed a diagnostic evaluation in November, 2007 based upon the Susan Barton framework for assessment of dyslexia. Ms. Snap concluded that Maggie had "classic dyslexia and dysgraphia" based upon family and educational history and "academic weaknesses consistent with dyslexia". Those included the following: weakness in phonological processing with nonsense words, difficulty with rote memorization, letter confusion, insufficient sound-symbol knowledge, problems with spelling and poor written expression compared to oral expression.

Educational Interventions
Maggie has attended XXX Unified School District schools since 2nd grade. The district uses Houghton Mifflin Reading Curriculum which is considered a research based curriculum. Prior interventions have included the following:

> First grade: Individual literacy action plan that provided work with reading specialist. No further information on the intervention is available.
>
> Second grade: Student Study Team meeting, participation in reading lab, leveled reading groups, preferential seating, and home activities. The SIPPS program was used with Maggie.
>
> Third grade: Follow up SST meeting, one-on-one assistance, small group reading lab, SIPPS, use of dry erase board, continued home based practice. Ms. Smithreports that Maggie participated in the Snoopy's Reading Program for one hour per day, 4 days per week.
>
> Fourth grade: Work with reading specialist (possibly based on Orton-Gillingham approach).

Behavior During Testing:
Maggie was assessed in two testing sessions. As noted in previous assessments Maggie was hard working and cooperative throughout our time together. She appeared comfortable with the assessment process and was able to sustain attention for appropriate periods of time. Maggie also engaged in conversation about non-school activities, such as her pets and family activities. She was animated and demonstrated good social skills and sense of humor in casual conversation. Maggie was pleasant and enjoyable to work and converse with.

Maggie reports that she enjoys reading, likes math and enjoys making up stories for writing but does not enjoy the process of writing.

Assessment Results:

Selected assessments were completed in order to address the referral concerns regarding Maggie's educational needs and appropriate services. The following discussion will utlize the results of these tests and previous testing.

Portions of the following tests were administered:
Woodcock Johnson Tests of Cognitive Abilities III (WJ-COG III)
Woodcock Johnson Tests of Achievement III (WJ-ACH-III)
Process Assessment of the Learner II (PAL-II)
Gray Oral Reading Test IV (GORT-IV)
Test of Silent Word Reading Efficiency (TSWRE)

The individual scores for these tests are presented at the end of this report. Like any such tests purporting to measure cognitive abilities or achievement, it is important to remember that these scores represent a sample of Maggie's behavior and must be considered in the context of other information. The tests used were appropriate for Maggie and the purposes for which they were used. Therefore, the results can be considered a valid measure of her current level of functioning.

Because the primary question centers on whether a diagnosis of dyslexia is appropriate for Maggie and her need for support services the findings will be reported within a format for assessment of dyslexia.

Does Maggie present evidence of an academic deficit?
Maggie demonstrates a mixed profile in academic assessment. She has consistently performed within the basic to proficient range on annual state mandated achievement testing (STAR) indicating attainment of grade level standards on the overall English/language arts assessments. However, she has demonstrated relative weakness in some areas such as decoding of multi-syllabic words and comprehension. In addition, classroom teachers have consistently expressed concern about Maggie's reading and written language skills and according to her mother, Maggie has been considered for retention during past academic years. As noted above, her parents also report difficulties at home with all reading and writing activities. School reports suggest that despite some basic skills deficits Maggie has developed good compensatory strategies in order to be successful in school. Following are results of assessments.

Word Specific Skills
Word specific skills include the ability to decode words and the ability to recognize words fluently. These are important to reading because skilled reading requires the ability to recognize words that one has seen before and to decode new words. In addition decoding skills are essential for beginning reading. Word specific skills are assessed in both timed and untimed conditions with real and nonsense words

Phonological Decoding skills: Phonological decoding skills tests measure the ability to use knowledge of phonics to read or spell accurately. On tests of decoding nonsense words Maggie's accuracy was in the low average to below average range and her fluency within the low average to average range. Her ability to encode (spelling of nonsense words based on phonics rules) was within the average range.

Morphological Decoding skills: Morphological skills include an understanding of word roots, suffixes and prefixes. Maggie demonstrated strong skills when using semantic and syntactic information to identify appropriate word endings and beginnings. However, she performed below average on measure of accuracy and fluency that relied on the use of morphological information.

Word identification: Maggie performed somewhat differently on the two tasks of isolated word reading administered. She performed in the low/below average range (SS=89, 24th percentile) on the WJ-ACH-III Letter Word Identification subtest and well below average on the word reading task of the PAL II. It is important to note that her relative proficiency index (WJ-ACH-III), which is a measure of how well Maggie

would be expected to perform in comparison to the average end of fourth grade student, indicates that when the average student would be expected to master 90% of the tasks relying on word reading, Maggie would likely only master 48% of the material which is an impaired level of classroom functioning. Maggie performs better in connected text, (accuracy on the GORT IV at the 25th percentile) and when choosing the correct spelling of a word based on appropriate suffixes and prefixes.

Fluency: Maggie performed well below the average range on a word reading fluency test (PAL-II, 5th percentile) and in the below average range on sentence reading tasks of both PAL II (20th percentile) and WJ-ACH-III (20th percentile). On the GORT-IV, she performed in the below average range in fluency for reading of connected text (6, 9th percentile).

Comprehension

On the GORT-IV, Maggie performed in the low average range (25th percentile) in comprehension of connected text, as measured by her ability to correctly answer multiple choice questions based upon the short passages read. It is important to note that such measures do not adequately assess how well a student might do with the extended subject matter reading required at upper elementary grades and beyond.

Written Language

Spelling: Maggie's spelling provides further information regarding her word specific skills. Her spelling of real words is low average (SS=87, 19th percentile) in current testing. Her errors tended to be phonetically correct and were often due to lack of knowledge about specific spelling conventions. Her spelling RPI indicates that when an average student exhibits 90% mastery of the spelling material Maggie would demonstrate mastery of 57% of it. This indicates an impaired level of classroom functioning. It is also important to know that Maggie's spelling is not automatic in that she tends to work slowly and makes frequent corrections. Maggie's ability to identify a correctly spelled word within an array is within the average range (PAL II Word Choice). In paragraph writing, Maggie tends to make more errors than would be expected given her spelling scores.

Handwriting: The PAL-II provides measures of handwriting accuracy and fluency. Maggie's printing is legible (she chose not to do cursive) but immature.

Composition: Her note taking and compositional fluency were within the low average to average range.

In summary, Maggie's academic scores in reading and written language present a mixed profile. She is consistently stronger in meaning related activities and weaker in those that rely more on isolated skills.

Is the academic deficit due to lack of instruction?

Maggie has been enrolled in a school using a research based curriculum since 2nd grade. It is not known what curriculum was used in kindergarten and first grade. In addition, she has received intervention support throughout her schooling. Though, detailed information about these interventions is not available, it can be concluded that Maggie has received core instruction and intervention support related to her academic difficulties.

Is the academic deficit due to other developmental or language/cultural factors?

Maggie does not display sensory or health impairments that could account for her academic difficulties and displays average to high average cognitive abilities. Maggie lives in an English speaking home and her academic deficits cannot be attributed to cultural or environmental factors.

Does Maggie demonstrate a cognitive processing deficit related to reading and/or written language?

Orthographic processing: Orthographic processing refers to the ability to store information about the letters in words. It is important in building up a store of rapidly recognized words. Maggie's orthographic

processing was assessed through subtests of the PAL-II. Her score on the orthographic coding composite was below the 10th percentile. She had difficulty with both recognizing and recalling letter groups seen in previous words.

Phonological processing: Phonological processing is the ability to mentally manipulate the sounds of language. It is an important foundational skill in learning to read. Phonological memory refers to the ability to use phonological codes for short term memory and recall. On previous testing with the Comprehensive Test of Phonological Processing Maggie scored within the average range when required to manipulate the sounds in real words and below average when required to recall and manipulate the sounds in nonsense words. In addition, her phonological memory (ability to remember and recall nonsense words and numbers) score was below average. On current testing Maggie performed below the average range on phonological processing tasks measuring her ability to segment and blend both syllables and phonemes but within the average range when identifying beginning and ending sounds (Composite score 13th percentile).

Morphological coding: Morphological coding is a measure of a student's ability to use knowledge about word structure, such as suffixes and prefixes and syntax. Maggie displayed strength on morphological coding tasks of the PAL II, performing in the high average range (75th percentile).

Naming speed: Rapid naming involves the ability to quickly name a series of over-learned items such as digits, letters or common words. It is tested under timed conditions. Thus it requires the student to view the stimulus, quickly retrieve its label, say it and move on to the next item. On previous testing with the CTOPP, Maggie performed within the average range. On current assessment Maggie received a score below the average range on the Rapid Naming Composite of the PAL II (6th to 16th percentile).

Verbal working memory: Verbal working memory tasks measure a student's ability to hold in memory verbal information (such as letters, words and sentences) while required to also perform some action with it. Maggie's verbal working memory composite score is well below average (5th percentile). However, it is useful to note the differences in her performance on the tasks that comprise the verbal working memory composite. When remembering and recalling the order of word spellings she performed better than when working with letters only. In order to recall letter order she had to recite the alphabet from the beginning each time and often got confused. Maggie does not appear to have automatic access to the over-learned material that most students her age do. On tests of sentence memory, she performed within the average range when recalling orally presented sentences but well below average when recalling sentences she was required to read (6th percentile). This may be due to her needing to put significant resources into reading the sentence – thus having fewer mental resources available for processing and remembering the sentence.

Orthographic Spelling: Maggie performed accurately and quickly when required to choose a correct spelling out of an array of words containing options that were all phonetically correct (e.g. was, wuz, whas). This is in contrast to her orthographic coding difficulties when relying on immediate storage and recall. It seems that once Maggie has a correct spelling in long term memory she is able to recall it accurately, but that she performs much worse at storing information after limited exposure. Thus, for Maggie it may take many more exposures to a word for that word to become easily and fluently accessible for her in reading and spelling.

Processing Speed: To further evaluate possible naming speed deficits the Processing Speed composite of the WJ-COG-III was administered to Maggie. She scored within the average range (Standard score = 104, 60th percentile) suggesting that deficits in rapid naming are not related to overall processing speed weaknesses.

Are Maggie's oral language skills in the average range?
As noted above, previous testing with the TAPS indicates average level oral language skills.

Is Maggie's verbal comprehension significantly higher than her reading skills?
Students with dyslexia demonstrate a significant discrepancy between verbal comprehension and basic reading skills. On previous testing with the WISC III, Maggie received a Verbal Comprehension Index score of 112 (79th percentile). This is significantly different from her score on the Letter Word Identification (82, 12th h percentile) and the Spelling (85, 16th percentile) subtests of the WJ-COG-III and her Rate score on the GORT-4 (6, th percentile). In addition, her timed list word reading is well below average (Standard score equivalent =75, 5th percentile) and her decoding is below average (Standard score equivalent = 81, 11th percentile).

Summary:
Maggie exhibits a contradictory and somewhat confusing profile. She clearly demonstrates processing deficits and academic strengths and weaknesses that are indicative of dyslexia. She has good oral language skills with strong verbal comprehension. On reading tasks she tends to do better on those that are helped by using her strong language skills. When she is required to rely more on decoding or her ability to create and store word forms she performs much worse. She shows significant deficits in orthographic coding, phonological coding, naming speed and verbal working memory – all areas known to be associated with dyslexia. In contrast her ability to use morphological information and her knowledge of syntax are strong. She is using these strengths to compensate for basic processing weaknesses. In addition, though legible her handwriting is immature and her written compositions have numerous spelling errors.

Like many older children with dyslexia her primary academic weaknesses are in fluency (particularly of isolated word reading) and spelling.

It appears that Maggie has used a variety of strategies to develop the store of automatically accessible word forms that children access when reading. However, she requires more exposures to a word in order for it to become automatically accessible to her, thus her store of such words is limited. Significantly she has relied on her good language skills to compensate for deficits in other critical areas (phonological processing and orthographic processing). Though successful for her this type of strategy puts her at a disadvantage as she has access to a limited number of words that she recognizes immediately and is likely to encounter increasing difficulties as vocabulary in content areas becomes more difficult. In addition, these compensatory strategies are costly in terms of mental resources and likely impact her academic performance. For example, on current memory testing, she performed much worse when asked to recall sentences she had read as opposed to those that were read to her.

In contrast to these obvious difficulties Maggie performs within the basic to proficient range on annual state testing linked to California standards and receives average grades. When considering the most appropriate supports for Maggie, it is important to note that Maggie has received ongoing intensive intervention both at home and school since first grade.

Recommendations:
As Maggie enters fifth grade it is important to consider both remedial interventions and compensatory strategies for her.

In regards to remediation there are two possible avenues of support. The first is to consider the least possible intervention that would target Maggie's area of need. Maggie is developing knowledge of phonics, understands morphological conventions and is developing a sense of legal and common spelling conventions. However, this knowledge is still at a fragile level for her; she does not have the mastery of these areas that results in consistently fluent and accurate performance. One possible intervention is a program such as *Great Leaps* that will target developing automaticity at critical letter sound and word skills.

Another possible intervention is one that focuses on her strengths in morphological decoding. Examples of such programs are *Words (Marcia Henry)* and the *Process Assessment of the Learner Intervention Guides.*

Another approach would be to begin an intensive intervention aimed at remediating the orthographic and phonological coding deficits that Maggie exhibits. An example of a more intensive intervention is *Lindamood Bell LIPS* and *Seeing Stars.* A more comprehensive approach would be a program such as *Reach (SRA Publications).*

Any such remediation program should monitor her progress in all five areas identified by the National Reading Panel to assure that Maggie has the necessary proficiency in each of these areas: phonological processing, phonics, fluency, comprehension and vocabulary.

As a student with dyslexia, Maggie is having difficulty developing the mental storehouse of word forms linking orthographic, phonological and meaning-related information about words. These linkages are critical to fluent reading and writing. Instruction and interventions that focus on all three forms of information about words will be the most helpful to her. This will help to foster more connections to the words she is learning and ultimately storing so that she can recognize them "on sight." Due to her difficulties with establishing mental representations of words it is important that activities are designed to create multiple connections between letters and sounds and words.

It is also important that Maggie learn keyboarding and if needed the use of word prediction software.

In addition to remediation it is important to consider appropriate accommodations for Maggie. Reading of content area texts and writing tasks are likely going to be difficult for her. Possible accommodations include taped texts, extra time for testing, reduced assignments, and support for reading in math and content area subjects. In addition, oral test taking should be considered in subject areas. An approach would be for teachers to compare her performance on written tests to the same test administered orally. When the goal is to evaluate Maggie's content knowledge some oral test taking may be useful.

Grading on written work should be modified for Maggie's spelling problems. A strategy such as not counting for spelling errors but asking Maggie to highlight any word she is not sure about is one possibility. In addition, penmanship should not be part of her grade. The use of supports such as a Franklin Speller or word prediction software is appropriate.

Maggie's mother reports that she is currently having difficulty with math computation. This may represent the rote learning difficulties of students with dyslexia. It is important that problems with basic math calculation or algorithms do not impede the development of her strong math reasoning skills. Therefore, it may be necessary to provide a calculator and supports for recalling the steps in basic math procedures.

As noted by Ms. Snap, it is possible that Maggie may have difficulty with learning a foreign language as this is a common problem for students with dyslexia. If so, accommodations should be provided.

In summary, Maggie is a student who exhibits characteristics indicative of dyslexia. She has also been compensating well for her cognitive weaknesses by working hard and relying on strong verbal comprehension skills. However, such a strategy will eventually takes its toll on a student and as the work becomes harder she is likely to struggle more. Therefore, it is important to determine the most appropriate strategies for both remediation and accommodation.

Thank you for the opportunity to work with Maggie. I enjoyed spending time with her and wish her the best in her future education.

Catherine Christo, Ph.D., NCSP
Licensed Educational Psychologist

GRAY ORAL READING TEST

Composite	Standard Score	Percentile
Rate	6	9
Accuracy	7	16
Fluency	6	9
Comprehension	8	25

WOODCOCK JOHNSON III

Subtest	Standard Score (Range)	Percentile	Rel. Prof. Index
Visual Matching	100 (91-109)	50th	90/90
Decision Speed	107 (98-116)	67th	93/90
Processing Speed Composite	104 (96-111)	60th	92/90
Letter Word ID	82 (78-85)	12th	43/90
Reading Fluency	85 (80-89)	16rd	85/90
Spelling	87 (80-93)	19th	57/90
Spelling of Sounds	98 (89-107)	45th	89/90

Recommendations:

Educational services:

1. Lee displays a significant discrepancy between her intellectual ability and current academic achievement in the area of reading skills. In addition, she has a disorder in the basic psychological process of associative memory. It appears that she will need more support than the regular classroom can provide. Therefore, Lee meets criteria indicating the need for special education services. The IEP team will determine the most appropriate educational services for Lee.

Reading intervention:

1. Though Lee knows sound/symbol associations, she is lacking facility with them. Thus a focus must be on ways to develop this facility. The development of letter sound knowledge will be enhanced by instruction that is well integrated. Therefore, instructional sessions for Lee should integrate all aspects of word study in close proximity to each other. That is, in the same session Lee should study letter combinations, syllables, words and texts that share letter patterns. She will benefit from being provided with many different sources of information about words (phonological, orthographic and morphological). Such a strategy will help to increase the number of connections Lee establishes and, consequently, has access to, regarding spelling patterns. Increased connections during each instructional period may facilitate the retrieval process (for example, *Reading Lesson Frames*, Berninger). Learning about the morphology of words may also be a useful approach.
2. Reading fluency is a significant area of concern. Programs based on increasing reading fluency should be explored. Two such programs are *Great Leaps* and *Read Naturally. Seeing Stars* also focuses on developing reading fluency.
3. Paired reading, in which Lee reads along with a partner who reads slightly ahead of her, may also be a worthwhile strategy.
4. Repeated readings, in which Lee reads a short passage for time and then works to increase her speed are also helpful in improving reading fluency.
5. Regular independent reading is critical for Lee. She should generally read books in which she has 90% accuracy. However, fluency gains have been found when children read books that are somewhat above their comfort range as well. Test results indicated oral text reading level at first to second grade level.
6. Considering Lee's reading speed she may have difficulty extracting information from grade-level, content area texts. Therefore, partnered reading or taped texts may be a useful accommodation until Lee's reading fluency increases.

Catherine Christo, Ph.D., NCSP
Licensed Educational Psychologist

READING DISABILITY ASSESSMENT REPORT LANGUAGE SAMPLE 3

NAME:	SAM SMITH	ASSESSMENT DATE:
AGE	9-YEARS, 1-MONTH	BIRTH DATE:
GRADE:	3	

REASON FOR REFERRAL

Sam was referred by his parents to help determine the etiology of basic reading skill development challenges and to assist in educational program planning.

PSYCHO-EDUCATIONAL PROCEDURES

The following procedures were used to obtain an estimate of Sam's current psycho-educational functioning: *Comprehensive Test of Phonological Processing*; *Test of Word Reading Efficiency* (From A)*; Gray Silent Reading Test* (Form A); *Process Assessment of the Learner: Test Battery for Reading and Writing*; *Parental Assessment of Development and Early Learning-Revised*; and review of prior assessment reports and data.

Background Information

Sam is a 9-year, 1-month-old, 3rd-grade-boy, who currently attends ABC School in Center, CA. He lives with his biological parents, Steve and Suzie Smith, and the primary language of the home is English.

Sam was evaluated by his school's IEP team in the spring of 2006 (at the end of his second grade year) due to reading difficulties. From the data generated by this evaluation the team concluded that he meet special education eligibility criteria (as a student with a specific learning disability). Specifically, it was determined that Sam demonstrated a significant discrepancy between his learning potential and his reading achievement, and that this discrepancy was due to an auditory processing deficit.

Ms. Smith's responses to the *Parental Assessment of Development and Early Learning - Revised* indicate Sam's current health status to be good. Vision and hearing are reported to be normal. The pre-natal history is without apparent challenges to normal development, and Sam was the product of a normal full term pregnancy and delivery. The birth weight was just over 9-pounds and all major developmental milestones were obtained within normal limits. Sam's early health history was complicated by frequent ear infections between the ages of 2- to 5-months. Reading fluency was reported by Ms. Smith to be the primary learning weakness. There is no family history of learning disabilities, and in fact the home environment appears to be one that highly values reading and is optimally supportive of Sam's reading skill development.

Social/emotional development appears to have been unaffected by Sam's learning challenges. He is reported to have stable peer relationships and is described by his mother as "funny, smart, makes great observations, still likes to cuddle, he is compassionate and caring."

Previous Assessment Findings

Sam was previously assessed in March and April, 2006, by Joan Jones, School Psychologist. Intelligence test results estimated Sam's intelligence to fall in the Superior to Very Superior range of scores.

According to the *Wechsler Intelligence Scale for Children – IV* (WISC-IV) his Full Scale IQ (129) likely falls within the range 124 to 132. With the exception of Working Memory, all *WISC-IV* Index Scores were above average. On the Working Memory Index Sam obtained a score of 97 (DS, 7; L-NS, 12). While normal when compared to age peers, this result can be considered a relative weakness for this extremely bright young man. This relative weakness was confirmed by the results of the *Tests of Auditory-Perceptual Skills – Revised.* In addition, the *Wide Range Assessment of Memory and Learning – 2* suggested visual memory to also be a relative weakness.

Last spring Sam was also assessed by Jill White, Resource Specialist. Achievement test results estimated Sam's math achievement to fall in the Very Superior range and his reading and written language to fall in the Average range. According to the *Wechsler Individual Achievement Test* (2nd ed.; WIAT), his Math Composite standard score was 150, and his Reading and Written Language Composite standard scores were 96 and 99 respectively. His lowest subtest results were Pseudoword Decoding (SS, 95) and Spelling (SS, 92). Most recently the *Gilmore Oral Reading Test* (4th ed.) was administered by Mary Nguyen, Resource Specialist. On this measure Sam obtained a Reading Rate standard score of 8, a Reading Accuracy score of 10, and a Reading Comprehension Score of 10.

Test Taking Behavior

Sam readily accompanied the examiner to the testing room and rapport appeared to be adequate. Level of activity and verbalizations were appropriate to the tasks at hand. His reaction to failure was also appropriate. Encouragement and praise appeared to improve Sam's test taking effort. It was the examiner's impression that Sam's effort was consistent. Overall, test results are considered an adequate reflection of Sam's present levels of functioning. However, as will be discussed below, it is important to note that there were two subtests in this battery that may not have yielded valid test results.

Test Results

The *Comprehensive Test of Phonological Processing* (CTOPP) assesses phonological awareness, phonological memory, and rapid naming. Students with deficits in one or more of these abilities may have difficulty learning to read. The Phonological Awareness Quotient measures awareness and access to the phonological structure of oral language. The Phonological Memory Quotient measures the ability to code information phonologically for temporary storage in working memory. The Rapid Naming Quotient measures the efficient retrieval of phonological information from long-term memory, as well as the ability to execute a sequence of operations quickly and repeatedly. The following Table summarizes Sam's *CTOPP* performance on these measures.

Subtest	Raw Score	%ile Rank	Standard Score	Composite	%ile Rank	Standard Score
Elision	6	9	6	Phonological Awareness	8	79
Blending Words*	8	16	7	Phonological Memory	12	82
Memory for Digits	9	9	6	Rapid Naming	5	76
Rapid Digit Naming	49	16	7			
Nonword Repetition*	9	25	8			
Rapid Letter naming	60	9	6			

*An audio equipment malfunction combined with some environmental distractions may have affected the validity of these subtest results and the obtained scores should be treated with caution.

These results suggest that Sam's awareness of the sounds that comprise oral language (Phonological Awareness), his ability to hold such information in his working memory (Phonological Memory), and his ability to retrieve information quickly and automatically from long-term memory (Rapid Naming) call all be considered significant weaknesses. For Sam, these data predict that relative to his age peers he might have difficulty manipulating sounds (an essential phonics skill), be slow at retrieving letter names and sounds from his long term memory, and also have difficulty holding such information in working memory while he attempts to construct meaning (i.e., recognize what the given word means).

The previously administered reading achievement test results suggest that Sam has made significant strides toward overcoming these challenges to the development of his reading skill. However, *CTOPP* data suggests that he will likely continue to find expository text challenging (especially text that contains words not within his sight word reading vocabulary) and will struggle constructing meaning from such text.

The *Test of Word Reading Efficiency* (TOWRE) is a measure of an individual's ability to pronounce printed words accurately and fluently. The test measures both the ability to sound out words and the ability to recognize familiar words as whole units or sight words. Sam's Total Word Reading Efficiency Standard Score of 78, falls at the 7th percentile rank and in the Poor range. The following Table provides a summary of Sam's *TOWRE* subtest performance.

Subtest	Raw Score	Age Equivalent	Grade Equivalent	Percentile Rank	Standard Score
Sight Word Efficiency	42	7-9	2.4	17	84
Phonemic Decoding Efficiency	9	6-9	1.6	9	80

This pattern of scores is consistent with parental concerns regarding reading fluency and Sam's *CTOPP* (Rapid Naming, 76) result. Scores at this level typically are interpreted as suggesting that intensive, explicit, and supportive reading instruction is required. These data further support the predictive hypothesis that Sam will likely struggle to construct meaning from expository texts. Especially when he is confronted with text containing words that are not in his sight word reading vocabulary (i.e., words that he needs to

"sound out"), he will likely find reading the words so challenging that it will be difficult for him to understand the instruction being offered by the text.

The *Gray Silent Reading Test* is a measure of silent reading comprehension. On this measure Sam obtained a Raw Score of 20, which corresponds to an Age Equivalent of 8-6, a Grade Equivalent of 2.8, a percentile rank of 39, and a Silent Reading Quotient of 96. These results suggest that when compared to his peers, Sam's ability to construct meaning from text that he has read silently to himself is within the Average range. This result is consistent with the previously administered *Grey Oral Reading Test.* This result further supports the observation that Sam has made significant strides toward overcoming the challenges to the development of his reading skill.

The *Process Assessment of the Learner: Test Battery for Reading and Writing* (PAL-RW) is designed to assess the development of reading and writing processes among children in kindergarten through 6th grade. Selected subtests from this measure were administered to assess Sam's phonological processing (i.e., his ability to hear and manipulate the sounds that comprise words), orthographic processing (i.e., his ability to mentally represent the visual depiction of written words in short and long term memory), rapid naming (i.e., his ability to automatically recognize and name letters, numbers, and words), and phonological decoding (i.e., his ability to apply phonological decoding) abilities.

Content Subtest	Raw Score	Decile Score	Classification
Phonological Processing			
Syllables	9	80	Proficient
Phonemes	19	40	At-Risk
Rimes	4	30	At-Risk
Orthographic Processing			
Receptive Coding (short term memory)	33	20	Deficient
Word Choice (long term memory)	13	40	At-Risk
Rapid Automatic Naming			
Letters	73	30	At-Risk
Words	42	30	At-Risk
Digits	101	10	Deficient
Words & Digits	81	10	Deficient
Phonological Decoding			
Pseudoword Decoding	20	40	At-Risk

Consistent with *CTOPP* results, it would appear the Sam has some phonological processing challenges. Specifically, while Sam's ability to segment spoken words into syllables is Proficient, he is considered At-Risk when it comes to his ability to segment spoken words into phonemes and to understand rimes (the portion of the syllable that is left [e.g., *end*] when the initial phoneme [e.g., *b*] or phonemes [e.g., *bl*] of the syllable is deleted). These results suggest the need for ongoing phonological awareness training (e.g., *Ladders to Literacy*, *Sound Partners*, and *Road to the Code*).

Sam's ability to initially code written words into his short term memory (Receptive Coding) is Deficient. The subtest assessing this skill required Sam to briefly look at a word and then immediately indicate if a second word, letter, or letter cluster was found within the word previously viewed. This suggests that he has difficulty creating accurate representations of written words within his short term memory after a single brief exposure. He appears to require multiple or longer exposures to words before he will be able to mentally represent it (an essential prerequisite to having the word become one that is immediately recognized by sight). Sam's ability to retrieve representations of words from his long term

memory (Word Choice) is At-Risk. The subtest assessing this skill required Sam to select the correctly spelled word from among three phonologically equivalent or similar words. His difficulty precisely retrieving mental representations of words from his long term memory is likely playing a role in his reading fluency challenges. These results suggest the need for orthographic training activities (e.g., playing writing, looking, and word-retrieval games).

Again consistent with *CTOPP* results, it would appear the Sam has significant rapid automatic naming challenges. Specifically, Sam's ability to rapidly name letters, words, digits, and words and digits can be described as At-Risk or Deficient. This weakness is likely at the heart of his reading fluency challenges. These results suggest the need for a repeated-reading program that promotes frequent practice with instructional reading level material containing the same words and text. Such a program may be especially helpful when paired with training in the alphabet principle (e.g., *Talking Letters Program*).

Consistent with *TOWRE* results, it would appear that Sam has difficulty reading pronounceable nonwords that can be decoded on the basis of spelling-phoneme relationships, but not by retrieval from long term memory of word-specific representations. As was mentioned earlier, these results predict that Sam will have difficulty sounding out unfamiliar words, and further suggest that explicit instruction in the alphabet principle will be critical (e.g., *Talking Letters Program*).

Summary and Educational Implications

Sam is a 9-year, 1-month-old, 3rd grade boy who has been evaluated to determine the etiology of basic reading skill development challenges and to assist in educational program planning. From the available data it is concluded that Sam's reading difficulties can be attributed to deficits in phonological awareness, rapid automatic naming speed, and orthographic processing. Combined these are classic indicators of a reading disability (or dyslexia).

It is significant to note that prior evaluation data suggests that Sam is an intellectually gifted individual and, in the area of math, an academically talented student. Given that his reading achievement test scores are considered to be "average," it is only when viewed from the context of his high IQ and math achievement that the true extent of Sam's reading disability becomes apparent. Clearly if it was not for his high verbal intelligence he would likely be experiencing much more significant reading difficulties. Of course the fact that he has a home environment that highly values reading and supports the development of these skills, and his current instructional program cannot be over looked as factors contributing to Sam's success in learning how to read.

While Sam's average (or grade level) reading achievement test scores clearly indicate that he has made significant strides toward overcoming his reading disability, it is the opinion of this examiner that he would benefit from an ongoing educational program aimed at further addressing his reading challenges. This is especially important given the examiners prediction that Sam will have difficulty constructing meaning from expository texts (i.e., textbooks that are designed to provide instruction). Especially when he is confronted with text containing words that are not in his sight word reading vocabulary (i.e., words that he needs to "sound out"), he will likely find reading the words so challenging that it will be difficult for him to understand the instruction being offered by the text. Thus, this report offers specific educational program interventions.

Finally, while the general profile provided by this battery is consistent with prior testing there are some discrepancies. Specifically, Sam's obtained scores on measures of pseudoword decoding and reading fluency are significantly lower than those obtained during previous test administration. To address this inconsistency additional testing will be recommended.

From the current battery of tests the following conclusions and recommendations are made:

1. Sam has basic psychological processing disorders (in other words he has a reading disability) in the areas of phonological awareness, rapid automatic naming speed, and orthographic processing. When combined with the fact that he demonstrates a significant discrepancy between his ability (IQ) and his reading and written language achievement, it would appear that he meets eligibility criteria as an individual with a specific learning disability [according to the California Code of Regulations - Title 5, Section 3030 (j)]. This conclusion is consistent with that reached by the IEP team convened to address Sam's reading differences last spring.

2. If the IEP team determines that Sam is not eligible for special education assistance, then it is suggested that a 504 accommodation plan be considered. Such a plan would focus on providing him with the support he needs to benefit from the general education program (e.g., providing textbooks on tape, using speech recognition software to assist in the completion of written assignments, etc.)

3. There are some discrepancies between current and previous testing, as well as some reason to question the validity of at least two of the subtests contained within the current test battery. Thus, additional testing is recommended. Specifically, the Pseudoword Decoding subtest from the *WIAT*, the TOWRE (Form B), the *GORT* (Form A), and the *CTOPP's* Blending Words and Nonword Repetition subtests should be administered/re-administered. Following administration of these measures this report will be amended.

4. Specific educational program recommendations to address Sam's anticipated learning needs include the following:

   (a) Phonological awareness training.

   (b) Orthographic training activities such as writing, looking, and word-retrieval games.

   (c) Frequent opportunities to read and re-read instructional level reading material containing the same words and text.

   (d) Alphabet principle training should be provided

It is important to emphasize that the final decision as to whether or not Sam meets special education eligibility criteria will be made by the Individualized Education Program (IEP) team, including assessment personnel, and will take into account all relevant material available. No single score or product of scores, test or procedure (including the data represented in this report) should be used as the sole criterion for the decision of the IEP team as to his eligibility for special education and/or the development of his instructional program.

Stephen E. Brock, Ph.D.
Nationally Certified School Psychologist
Licensed Educational Psychologist

SAMPLE SURVEY LEVEL ASSESSMENT RESULTS

Student: Jonathon
Grade: 6
Date: 8/29/07
Examiner:

Jonathon was given a baseline assessment in the areas of phoneme segmentation fluency, nonsense word fluency, and oral reading fluency. Each of these areas were assessed using the DIBELS assessments. Jonathon appeared to put forth effort during testing. The reward of classroom 'tickets' were used as an incentive for Jonathon to complete the assessment.

DIBELS Phoneme Segmentation Fluency (PSF)

The PSF measure is a test of phonological awareness that assesses Jonathon's ability to segment three and four phoneme words into their individual phonemes fluently. Jonathon was asked to produce verbally the individual phonemes for each word. For example, the examiner said, "sat," and the student says, "/s/ /a/ /t/." The following results show the number of correct segments Jonathon said in one minute.

Trial 1	Trial 2	Trial 3	Median # Correct Segments
31	30	23	28

The goal for Jonathon on PSF is 35 correct segments per minute. Jonathon's median number of correct segments was **28**.

DIBELS Nonsense Word Fluency (NWF)

The NWF is a test of the alphabetic principle- including letter-sound correspondence and the ability to blend letters into words in which letters represent their most common sounds. Jonathon was presented a paper with randomly ordered VC (vowel/consonant) and CVC (consonant/vowel/consonant) nonsense words (e.g. sig, rav, ov) and asked to produce verbally the individual letter sound of each letter or verbally produce, or read, the whole nonsense word. The following results show the number of correct letter sounds Jonathon said in one minute.

Trial 1	Trial 2	Trial 3	Median # Correct Letter Sounds
52	46	47	48

The goal for Jonathon on NWF is 50 correct segments per minute. Jonathon's median number of correct segments was **48**.

DIBELS Oral Reading Fluency (ORF)

The ORF is a test of accuracy and fluency with connected text. Jonathon was presented with 3 passages in the 1st, 2nd, and 3rd grade levels. He was asked to read each passage aloud for one minute. The following results show the number of words read correctly/errors that Jonathon read.

Passage Grade Level	#1 WRC/E	#2 WRC/E	#3 WRC/E	Median WRC/Errors	Performance Level
1	80/3	77/4	73/4	77/4	Mid Instruction
2	70/1	53/1	55/5	59/2	Low End

					Instruction
3	50/10	56/7	66/5	57/7	High End Frustration

The above results should be used to determine the instructional level and appropriate level for progress monitoring. It is also recommended that Jonathon's low end instruction level be used. As shown above, Jonathon's low end instructional level is the 2nd grade. A likely goal is approximately a gain of 1.5 WRC/week in oral reading fluency.

It is proposed that to monitor Jonathon's progress, the DIBELS Progress Monitoring be used in the areas of phoneme segmentation fluency, nonsense word fluency, and oral reading fluency at the second grade level. These assessments would be administered one to two times per week, with the results charted towards making the goals recommended above.

REPORT OF COMPREHENSIVE EVALUATION FOR REFERRALS AT TIER 3

Within an RtI model, students who have not responded to interventions at Tier 1 and 2 are referred for a comprehensive evaluation to determine their need for more intensive services and possible special education eligibility.

1. Reasons for referral and statement of problem
    - Who made referral
    - Behavioral statement of concerns
2. Relevant background information
    - School history
    - Family
    - Health
    - Development
    - Other relevant data
    - Provided the opportunity to learn
3. Academic performance
    - Standardized measures
    - Curriculum based measures
    - Cum file
    - Work samples
    - Teacher reports
4. Rule out of exclusionary factors
    - Language
    - Other disability
    - Economic, environmental advantage
    - Lack of instruction
5. Response to interventions
    - Identify interventions and discuss
    - Describe history in interventions
    - Discuss students response
    - Discuss response of other students to this intervention
6. Further data regarding instructional need beyond regular education
    - Specific marker variables
    - Observational data
    - History
    - Cognitive assessment
7. Further data relevant to planning interventions
    - Environmental factors
    - Motivational factors
    - Pattern of strengths and weaknesses
8. Recommendations
    - Include specific information regarding interventions
    - Include information from “psychological” perspective
    - Include monitoring and follow up information

SAMPLE INTERVENTION PLAN

Identifying Information

Name: Britney Spears
Parents: Tom Spears and Maria Paris
Date of Birth: 8/26/96
Gender: Female
Age: 9
Tutor: Marcie Ortiz
Grade: 3rd
Current Placement: General Education, Public School

Description of Student

Britney is a nine year-old third grader who attends Washington Elementary School located in the city of Emerald. She was retained this year and is repeating the third grade. When asked why she was retained Mr. Spears stated that is was because of Britney's overall low academic performance. Britney was somewhat shy and reluctant to make conversation beyond simple, short answers during the first weeks of clinic. Yet she appears to be more comfortable with her tutor. When asked how she felt about school, Britney communicated overall positive comments. Specifically, she stated that she likes her teacher, because she often calls on her in class. She also said that she always works hard at assignments given by this teacher. However, she did note that she usually needs a lot of help when doing these assignments and is not always successful at getting them done.

Reason for Referral

Britney was referred to the Educational Psychology clinic for remediation services by her mentor Sue Thomas. According to the referral form filled out by Ms. Thomas, Britney's main areas of concern are: literacy, math and study skills. She stated that Britney "must do better at school because she always has problems with homework and study skills." In a file review it was noted that Britney's previous teacher wrote the following: "While Britney has improved with decoding and oral comprehension, she needs to increase fluency and written comprehension."

Interview Results

Britney's father, Tom Spears and her mentor Sue Thomas were both present for the interview. Mr. Spears, expressed concern regarding Britney's reading difficulties. He also stated that she has a lot of difficulty knowing what to do on an assignment and will often spend little time doing her homework and studying. Ms. Thomas reported that Britney has poor organizational skills and always needs extra assistance with her work.

Functional Assessment of Academic Behavior

This interview tool (FAAB)**,** allowed Britney and her father to give more specific information regarding her overall performance in school. Britney communicated that most assignments were interesting to her and she sometimes wanted to do a good job on assignments. However, she felt that she rarely did well on assignments. She stated that she felt most successful at school work when she was writing and when she asked the teacher for help.

Mr. Spears communicated many areas of concern for his daughter. These included: reading difficulties, following directions, knowing what to do on an assignment, skill level, organizational skills, spending little time studying, needing extra assistance, and spending too much time watching TV. However, he did state that Britney's area of strength is that she is well behaved at school, as well as home. He also noted that her attitude regarding school has changed dramatically this school year, with a much more positive outlook. He was also content with the fact that there is good communication between the school and home regarding Britney's progress. He did note that either older sister Wendy or mentor Liz will help with Britney's school

work, as he is unable to. Mr. Spears also stated that he often communicates to his children the importance of an education and how vital it is to be successful in life.

Present Levels of Performance

Woodcock-Johnson Test of Achievement-III. The following results were found in this standardized achievement test: Britney scored a standard score of 91 (28th percentile) in Broad Reading, which measures decoding, reading speed, and the ability to comprehend reading. She demonstrated more difficulty in Broad Math with a standard score of 87 (18th percentile). Broad Math measures mathematics reasoning, and problems solving, number facility and automaticity. Broad Written Language was an area of strength with a derived standard score of 109 (72nd percentile). This area measures production of written text, including spelling ability, writing fluency, and quality of written expression.

Curriculum Based Measurement Results. The focus of Britney's assessment was oral reading fluency as judged by how many words she could read correctly per minute. Baseline data were collected on 10/10, 10/11 and 10/17 with CBM probes provided by Dynamic Indicators of Basic Literacy Skills (DIBELS). The results of these probes were as follows:

3rd Grade Probes:

- Probe 1: 81 Words Correct Per Minute (WCPM) with 2 errors
- Probe 2: 73 WCPM with 5 errors
- Probe 3: 85 WCPM with 1 error

4th Grade Probes:

- Probe 1: 58 WCPM with 4 errors
- Probe 2: 68 WCPM with 4 errors
- Probe 3: 59 WCPM with 2 errors

Since the instructional placement standard for oral reading fluency at grades 3-6 is between 70-100 words per minute, Britney is currently reading at a third grade instructional level. However, because Britney is the age of a fourth grader, her oral reading fluency rate was targeted for improvement. Interventions will based on third grade reading level materials. However, progress monitoring probes will be administered at the fourth grade reading level.

Experimental Analysis of Academic Behavior

- **Fluency-** As measured by repeated readings of same probe
  1st Reading: 78 WCPM, 2 errors
  2nd Reading: 101 WCPM, 8 errors

These results show that Britney's oral reading fluency rate is influenced by practice. However, her errors did go up significantly on the second reading. She will need to be reminded that while it is positive to read at a relatively fast rate, it is just as important to read accurately.

- **Motivation-** Britney was instructed that if she could increase her WCPM by 30% over the baseline probe, she would be given a very cute puppy calendar.
  Baseline Probe: 69 WCPM, 2 errors
  Probe with motivator: 96 WCPM, 6 errors

Based on these results, it appears that motivation is a factor in Britney's performance in oral reading fluency. The fact that her WCPM went up 27 words after a reward was offered to her, suggests that motivation is a factor that should not be ignored during the intervention process.

- **Acquisition-**This was measured using a technique called *phase drill.* This consisted of having Britney first read a probe; recording her WCPM then highlighting all misread words. After, Britney read each word and sentence containing each word aloud three times. She then reread the passage and a second WCPM was recorded.

  1st Reading: 67 WCPM, 3 errors

  2nd Reading: 66 WCPM, 11 errors

The second reading was compromised by the fact that Britney skipped a whole line in the probe, which were counted as errors. This lead to her second score showing little to no effect of the phase drill technique. However, the number of words correct per minute did not increase, despite the phase drill, suggesting Britney does not require interventions related to acquiring new reading strategies.

Description of Targeted Skills

Oral Reading Fluency

Baseline: 59 WCPM, 2 errors (median), 4th grade reading level (taken from 3 baseline data points).

Intervention Goal: 65 WCPM on 4th grade reading probes by 11/28/05 (1.1 words per week *ambitious* over the period of six weeks).

Objectives:
1) Britney will read 60 WCPM by 10/25/05
2) Britney will read 61 WCPM by 11/1/05
3) Britney will read 62 WCPM by 11//8/05
4) Britney will read 63 WCPM by 11/15/05
5) Britney will read 64 WCPM by 11/22/05
6) Britney will read 65 WCPM by 11/29/05

Instructional Strategies Used To Increase Oral Reading Fluency Rate

1) Reading Passage Preview-This technique involves having the tutor read part of the passage for approximately one minute while Britney follows along silently. Reading rate of tutor will be relatively slow with good intonation. After this preview, Britney is to read the same part while receiving corrective feedback (e.g. reminding Britney to use appropriate expression, pause at commas and periods). This previewing method allows Britney to hear the passage read fluently and to practice by reading silently. It also provides her with the opportunity to become familiar with the material and to hear potentially difficult words pronounced clearly and correctly.

2) Presenting Key Words Prior To Passage-This will involve the tutor picking out key words before each passage is read. Britney and the tutor will discuss the key words (e.g. definition, how they are pronounced, how it used in the story) prior to the preview. Then the reading passage preview will continue as described above.

3) Fold-in-This technique will involve having Britney read a selected passage for one minute. This passage should contain no more than 50% unknown material. After she has read one minute, Britney's WCPM is calculated and this is number is labeled as *presession reading fluency.* As Britney reads, three words that she has difficulty with or doesn't appear to know will be noted and written on index cards. Then the tutor will write seven words that Britney did appear to know on other index cards. It is key that these known words be meaningful to the text and not simply words such as *a, the, of,* etc. Next, the tutor will present the first unknown word and will define it and use it in a sentence. Britney will then repeat the definition and use it in a different sentence. At this point the "folding-in" begins. The unknown word is read followed

by an known word. Then the unknown word followed by two known words, etc. This pattern is continued until all seven known words and one unknown words have been presented. This is continued with two other unknown words. Upon the completion of the fold-in Britney will be asked to re-read the passage and WCPM are calculated. This is known as the *postsession reading fluency* and the results will be graphed in order for Britney to visually see her progress.

4) Motivational Strategies-Based on parent interview and the results of experimental analysis of academic behavior, motivation does appear to be a factor in Britney's overall academic progress. Thus, consistent praise and feedback will be used in each session. Also, performance based rewards such as folders, calendars, and opportunities to play games with tutor will be used to increase Britney's motivation to increase her oral reading fluency rate.

INTERVENTION SUMMARY REPORT SAMPLE 1

Name: Donald Duck
DOB: 1/3/93
Grade: 6th
Tutor: Jeremy Kaplan
Number of Sessions: 16

Parents: Melanie and Felipe Duck
Age: 12
Current Placement: General Education
Peer Advisor: Katy Nichols
Date: 12/13/04

Reason for Referral

Donald was referred to the Educational Psychology Clinic by his mother and father for remediation. His presenting problem at the time of referral was reading. According to a former teacher, Donald is "reading two years below grade level". Mr. and Mrs. Duck reported that Donald has problems sounding out vowels, reads too quickly and carelessly, and gets frustrated to such a degree while reading that it inhibits his ability to finish his schoolwork in a timely manner. Donald'ss report card indicated that he is receiving B's and C's in all of his classes, with a C in Language Arts. Mr. and Mrs. Duck, during an initial interview, conveyed that they would like Donald to learn how to read more "smoothly". At the time of referral, Donald's goal was to "read better" because he felt he was not good at it, had particular anxieties about reading aloud and became frustrated when he encountered a word he did not know while reading.

Previous and Currently Attempted Interventions

Donald has experienced previous remediation services; he attended a Cerritos College clinic last year for help with his reading. Behavioral interventions have been attempted by his parents with the goal of increasing his motivation to complete schoolwork and improving his academic outcomes. Mr. and Mrs. Duck have tried removing TV time as a punishment for not completing schoolwork and have rewarded him for good academic behavior (e.g., finishing homework early in the day, a good report from school, etc.) by taking Donald to get ice cream.

Pre-Intervention General Academic Functioning

Reading

The focus of Donald's assessment was oral reading fluency (i.e., how many words he can read in one minute). He was assessed on 10/19/04 with six CBM probes provided by Dynamic Indicators of Basic Early Literary Skills (DIBELS); three at the fifth grade level and three at the sixth grade level.

6th Grade Level Probes
Probe 1: 118 Words Correct Per Minute (WCPM), 8 errors
Probe 2: 106 WCPM, 5 errors
Probe 3: 99 WCPM, 5 errors

5th Grade Level Probes
Probe 1: 92 WCPM, 4 errors
Probe 2: 97 WCPM, 1 error
Probe 3: 115 WCPM, 5 errors

Donald's performance on these probes indicated that he is able to fluently read 5th and 6th grade material independently. However, the average 6th and 7th grade student reads between 125 and 150 WCPM; therefore Donald's oral reading fluency rate was targeted for improvement.

Description of Targeted Skills

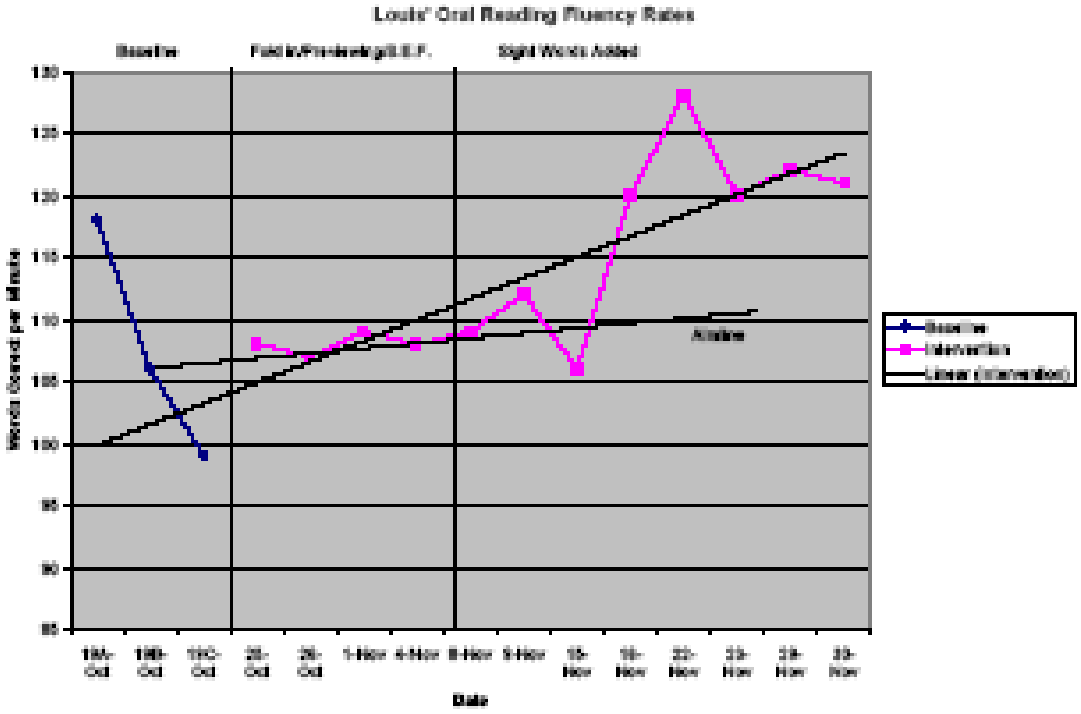
Oral Reading Fluency

Baseline: 106 WCPM, 5 errors (Median); Instructional Level- 6th grade

Intervention Goal: 111WCPM on sixth grade level reading probes by 11/30/04

Objectives:
1) Donald will read 107 WCPM by 11/04/04
2) Donald will read 108 WCPM by 11/09/04
3) Donald will read 109 WCPM by 11/16/04
4) Donald will read 110 WCPM by 11/23/04
5) Donald will read 111 WCPM by 11/30/04

Post-Intervention Results: 121 WCPM on sixth grade level reading probes on 11/30/04



Instructional Strategies Used To Increase Donald's Oral Reading Fluency Rate

Sight Word Vocabulary Techniques

Strategies to increase Donald's ability to identify and fluently read unfamiliar words constituted the largest part of this intervention. The fold-in technique and sight word drills from the *Seeing Stars* 1000 sight word list were the two techniques used to increase Donald's sight word vocabulary.

1) Fold-in

The fold-in technique involved having Donald read a grade level passage/book for one minute while the tutor followed along on his own copy. Donald's WCPM were then recorded. In addition, 3 words Donald struggled with (unknown words) and seven he read fluently (known words) were written on note cards. Donald was then drilled on the newly created "practice sight words" and known words in approximately 122 repetitions. Before the presentation of an unfamiliar word, the tutor defined it and used it in a sentence. Donald repeated the definition and used it in a new sentence. After the repetitions, Donald reread the same story and consistently read more of the passage within one minute due to the practice drill (on average, Donald read 12 more words). Subsequent fold-in sessions began with a review of the previous session's words. Eventually, previously unknown words were included as some of the seven known words included in the drill. This technique was effective for sight word acquisition and positive feedback; Donald was encouraged to note how much further he got in the passage when he reread it after the drill.

2) Sight Word Drills

Using the *Seeing Stars* 1000 sight word list, Donald was drilled with commonly appearing sight words. He was asked to read from a copy of the list while the tutor followed along on his copy. Any of the words Donald did not immediately and fluently pronounce were written on note-cards for review in the clinic. No more than ten awkwardly pronounced words were written down in any one session, in an effort to prevent overwhelming Donald.

Sight Word Vocabulary Techniques - Benefits/Effects

This technique was a successful approach to improving Donald's oral reading fluency rate, as well as promoting confidence in his reading ability. Donald, through drilled repetition of frequently appearing vocabulary words, showed marked improvements in his reading rate. For example, during the first few sessions of the intervention Donald frequently confused the pronunciation of the words "were" and "where" while reading in his copy of *Harry Potter* or *Roberto Clemente*. After drilling Donald with the proper pronunciation of these two words (both of which appeared on the *Seeing Stars* list) he was able to read passages from the two texts more rapidly and accurately, no longer needing to decode either word. Furthermore, reading more words per minute from the selected fold-in passage after the drill session became a source of pride for Donald (indicated by his smiling and counting the extra words he read); he was able to witness improvement in his own reading during many of our tutoring sessions.

Strategies to Promote Confidence in Donald's Reading Abilities

1) Specific Praise

During intervention, Donald was praised for trying and pronouncing new words, as well as decoding new words rather than guessing them. Motivation appears to be a significant factor influencing Donald's reading performance; praise was a successful technique used to increase his motivation to "take risks" when attempting to pronounce new and difficult words while reading aloud.

2) Feedback

Feedback about Donald's improved performance on probes (e.g., showing him his progress monitoring graph, noting how many words he was able to read on probes after completing them) and improvements in reading during the fold-in sessions served to provide Donald with tangible evidence that he is a good reader and that he has made improvements in his overall reading. In addition, he has been made aware that he is

reading material at his own grade level during this intervention. It was intended that education and feedback regarding his reading competency would help contribute to a more positive self-impression for Donald.

3) Previewing

This technique had Donald read a page of *Harry Potter* or *Roberto Clemente* to himself (silent previewing) or listen while the tutor read a page aloud (listening previewing), followed by Donald reading that same page aloud. Previewing allowed Donald to "practice read", providing him an opportunity to become familiar with any words he needed time to pronounce or hear. By giving Donald time to practice or a chance to hear and learn new words, it helped to alleviate some fears he had of reading aloud, while again bolstering confidence in his reading ability.

Strategies to Promote Confidence in Donald's Reading Abilities - Benefits/Effects

Donald thrives on verbal praise for his reading and evidence that he is improving in skill. Rewarding Donald for his strides during the intervention and attempts to conquer his fears of reading and decoding new words aloud were the most frequently praised behaviors during the sessions. These two behaviors, as well as praise for reading passages more carefully, were powerful aids in increasing his reading fluency rate, while promoting confidence in his reading abilities. Great efforts and gains were made during this intervention to convince Donald that he is a capable and talented reader and that continued effort in this area will translate into further gains.

Recommendations

1) Encourage Donald to read for pleasure for at least a half an hour a day. Repeated exposure to reading material will serve to increase Donald's acquisition of new vocabulary words, positively affecting his reading fluency. Donald has a great and diverse interest in books (particularly in the adventure, fantasy and sports genres); helping him choose books from his preferred genres will increase the likelihood that Donald will read books other than those required for school.

2) Encourage Donald to approach an adult or peer for help with of the pronunciation of new vocabulary words or words he may have difficulty pronouncing fluently. These words can be written down on index cards and practiced with Donald. Practice with the proper pronunciation of novel words will help increase Donald's sight word vocabulary repertoire. However, Donald should be encouraged to persist in his attempts to decode novel words before seeking help.

3) Inform Donald's teachers that he prefers warning before he is expected to read aloud. If he is given time/practice to read certain passages silently or with the aid of a teacher/parent before class, he may move closer to overcoming his fear of and frustration with making errors while reading aloud. Eventually, Donald may not need advanced warning of public reading as his confidence in his reading grows.

4) Provide praise for good effort and persistence by Donald; motivation is a significant influence on Donald's success. He appreciates and responds to praise for improvements in his oral reading and attempts to decode new vocabulary words.

Future Skill Areas to be Targeted

Future interventions with Donald should continue to focus on his oral reading fluency. Repeated practice with new sight words and more opportunities for Donald to read for pleasure will continue to be beneficial

in preparing Donald for his transition to seventh grade academia and beyond. Promoting Donald's confidence in his reading abilities should also continue; once Donald is convinced that he is a good reader he will begin to take pride in all academic endeavors that require this skill.

Conclusion

In conclusion, Donald made significant progress in reading over the 16 sessions. He exceeded the goals of the intervention in his rate of oral reading fluency. At the end of the sessions, Donald was reading at a rate more commensurate with an average 6th or 7th grader. Equally important, Donald appeared to become more comfortable reading aloud and in his competence as a 6th grade reader. His reading sounded more "smooth" (less errors, more quick and accurate pronunciations) after practicing new vocabulary/sight words, as well as words that were previewed in his reading passages. In addition, Donald began to take more care in decoding words and asking for help with the pronunciation of novel words. The generalizability of the success of this intervention should be attainable outside of the clinic.

I recommend no further remediation services for Donald; allowing Donald the opportunity for continued development of his reading skill can be accomplished at home and at school, with persistence on his part and the continued aid of his parents and teachers.

JK	KN	Dr. Powers
School Psychology Student	**Peer Consultant**	**Professor, CSULB**

INTERVENTION SUMMARY REPORT SAMPLE 2

Name: Sammy Pammy
Date of Birth: 8/11/1994
Grade: 3rd
Current Placement: General education, public school
Parents: Michelle & Shelby Pammy
Tutor: Sayaka Adachi
Intervention Dates: 2/18-4/30

Gender: Female
Age: 9
Retention: Once in second grade
Referred by: Parents
Number of sessions: 16
Date of Report: 5/8/04

Reason for Referral

Sammy was referred by her mother to the tutor for remediation services. According to Mrs. Pammy and review of the records, although Sammy is average academically compared to the national norm, she is struggling with all academic subjects in her current class due to the high standards of the school and the teacher.

Previous and Currently Attempted Interventions

Sammy was retained in the second grade. Sammy has been receiving reading and language intervention at school for the last three months. The intervention at school seems to be helping Sammy read more fluently and comprehend better.
Sammy started taking a stimulant medication for her Attention Deficit Hyperactivity Disorder (ADHD) on April 19th. The medication is at the trial stage: the psychiatrist and the parents are determining the most effective dosage at this time.

Pre-Intervention General Academic Functioning

In order to assess Sammy's math calculation skills and fluency, the tutor administered math probes which included 1) two digit by two digit addition with regrouping, 2) two digit by two digit subtraction with regrouping, 3) one digit by three digit multiplication, 4) two digit by two digit multiplication with regrouping, and 5) two digit by one digit division for a total of 20 problems that can result in a total of 70-80 digits correct. The probe was administered three times each day for three days. Her median score for the digits correct per two minute was 13 with 4 errors.

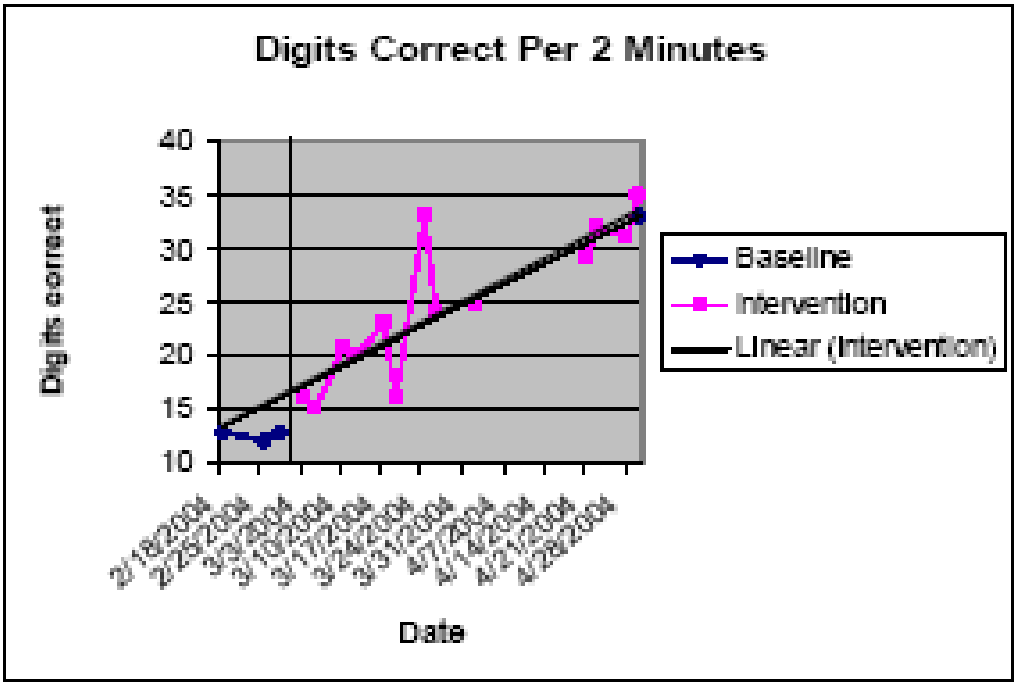
Description of Targeted Skills

1. Baseline/ Present Level of Performance: 13 digits correct per 2 minutes with 4 errors.

2. Intervention Goal: 18 digits correct per 2 minutes

3. Objectives:
    - Sammy will accurately solve two digits by two digits subtraction with regrouping by week 4.
    - Sammy will accurately solve 3 digits by 1 digit multiplication problem by week 6.
    - Sammy will accurately solve 2 digits by 2 digits multiplication problem by week 8.
    - Sammy will accurately solve 2 digits by 1 digit division problem by week 9.
    - Sammy will accurately solve mixed problems at 18 digits correct per 2 minutes rate by week 10.

4. Post-Intervention Results (Please refer to the graph below)
    - Sammy is able to accurately solve mixed problems at 35 digits correct per 2 minutes.
    - Sammy exceeded her goal in math.



Instructional Strategies to Promote Math Facts Calculation and Speed

1. Direct Instruction

Sammy received direct instruction on math concepts. This included subtraction with regrouping, multiplication facts, 3 digits by 1 digit multiplication, 2 digits by 2 digits multiplication, 2 digits by 1 digit division, and 3 digits by 1 digit division.

> ***Benefits/Effects:*** Sammy learned how to do all of the above mentioned math concepts quickly. Sammy seemed to benefit from one on one attention from the tutor as well as individually paced instruction.

2. Review of Basic Facts

This repeated practice strategy was used in order to increase Sammy's calculation speed. When the tutor gave two numbers, Sammy will either reply with the sum, difference, product, or quotient according to the tutor's request. This strategy can be used in three ways: 1. simply asking Sammy to reply as quickly as possible; 2. throwing a ball while asking the question and answering; and 3. compete with another person when tutor asks the question.

> ***Benefits/Effects:*** All of the three strategies were effective in increasing Sammy's basic facts memorization and recall speed. Using a ball was effective in reducing Sammy's use of her fingers when doing calculations. The competition was effective in improving accuracy while under the timed pressure. Sammy's improved speed is reflected on her probe scores.

3. Guided Practice and Independent Practice

When Sammy learned a new concept, Sammy practiced applying the strategy under the tutor's guidance. At this time, Sammy could ask questions for clarification. The tutor corrected her mistakes immediately and redirected her. Once she could solve the problem independently, Sammy solved 5-10 practice problems under timed condition. Timed independent practice increases fluency. It also mimics the timed test situation, so Sammy could learn to attend to problems instead of panicking.

> ***Benefits/Effects:*** Sammy was able to learn all the math concepts as described above. Sammy was given plenty of opportunity to practice newly learned skills under the tutor's supervision so she learned the process the right way. By practicing independently, Sammy was able to solve the problems more automatically.

Recommendations/ Future Skills to be Targeted

- Continue practicing basic math facts such as subtraction and multiplication facts. Although Sammy has improved in this area tremendously, she still does not recall them automatically.
- Whenever Sammy learns a new math process, such as a long division, encourage Sammy to think about why Sammy should solve the problem in a certain way. By thinking about why, Sammy will remember how to solve problems in the future.

- Encourage Sammy to think about math whenever possible. For example, ask Sammy to figure out which milk is cheaper by ounce at the grocery store.
- Whenever possible, encourage Sammy to solve simple math problems as quickly as she can. Speed is one of her strength. Knowing how to do things quickly or automatically will help Sammy pay attention to more important aspects when solving word problems.

Conclusion

Sammy's progress in math is remarkable. The tutor had to adjust the goals upward two times because Sammy kept progressing faster than anticipated. Sammy has learned how to subtract with regrouping, 3 digits by 1 digit multiplication, 2 digits by 2 digits multiplication, 2 digits by 1 digit division and 3 digits by 1 digit division. Sammy has also learned some strategies to help her calculate faster. Sammy can solve all of the problems on the probe accurately if given enough time to do so.

		Kristin Powers, Ph.D
Tutor	Peer Consultant	Professor, CSULB

PSYCHOLOGICAL PROCESSES
Dorothy Marshall, Ph.D.

Please answer this multiple choice question:

Psychological processes:

1. **Are essential to the legal definition of LD**
2. **Are ways of dividing up intelligence**
3. **Underlie learning disabilities**
4. **Do not affect basic "intelligence"**
5. **Help us understand individual strengths and weakness**
6. **Are not clearly related to academic interventions**
7. **Don't really exist**
8. **All of the above**

Yes, you guessed it. All of the contradictory statements listed above are correct! How can this be? Read on.

The 2004 IDEIA (Individuals with Disabilities Educational Improvement Act) special education law defines a specific learning disability as "**a disorder in 1 or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations…."** [Federal Register; Vol.71, No. 156, p.46757, Section 300.8 (10)]

This definition remains unchanged from the 1997 IDEA. The federal law gave no insight as to what the basic psychological processes might be. However, California State Regulations were very explicit in stating that eligibility for special education depended on a discrepancy between ability and achievement due to a disorder in one ore more of the basic psychological processes including

a. Attention
b. Visual processing
c. Auditory processing
d. Sensory-motor skills
e. Cognitive abilities, including association, conceptualization, and expression.

The discrepancy between ability and achievement is no longer required, (although the final revised regulations state that use of a discrepancy cannot be prohibited).

As of the writing of this handout, on June 22, 2009 new state special education regulations were not available. We do not know if the above list of processes or a comparable one will appear in the California regulations. A comprehensive evaluation is required for special education eligibility for learning disabled students. This is in addition to the requirement that the student, "fails to make sufficient progress to meet state approved results in one or more academic areas…. after a scientific research based intervention process." This is the response to intervention criterion (RTI).

At this writing the nature of the comprehensive evaluation is unclear. Districts may choose to require an evaluation of cognitive ability similar to what was done in the past. Since there will be less concern about an achievement/intelligence discrepancy than before, a process evaluation, de-emphasizing global I.Q., may well fill the need.

Are there other reasons to do a comprehensive, process oriented evaluation in addition to fulfilling eligibility criteria? Of course there are. These evaluations help teachers and parents understand their children, their learning strengths and weaknesses, what can be expected of them, where they will need extra help and how best to "bring them up to grade level." There will be less pressure to summarize a student's performance with a global IQ score and more opportunity to present a differentiated abilities pattern.

We can endlessly discuss just what a psychological process is and how these processes are related to "general intelligence" and school achievement. For decades, no, for at least a century, psychologists have been trying to understand what is at work in our minds/brains when we perform well or poorly on an I.Q. test. There is now general agreement that intelligence is not a unitary ability. But how to divide it up? According to Alan Kaufman, author of the KABC,
"*Dividing up cognitive abilities is like slicing smoke" (*remarks delivered at the 2005 CASP convention).

A process is a series of events leading to an outcome. In the future we will understand psychological processes as neural networks or modules that enable learning and intelligent behavior. For the present we must thinks of psychological processes as constructs or hypotheses…they are inferences from test scores and observations of behavior that are not pinned down to any structure in the brain. In this sense they "do not really exist". How they are classified or labeled will certainly change.

Because psychological processes can best be conceptualized as ever changing *hypothetical constructs,* about which there is little agreement, there are as yet few scientifically proven relationships between learning interventions and processes.

This is the basis of the criticism that process evaluations are not needed for LD special education eligibility. They do not "inform instruction". This controversial topic can generate much heat and we do not need to review all the discussion at this point. The bottom line for this writer is that most educational institutions do not have the resources to tailor instruction to the needs of the individual student. Even consistent small group intervention for 8 to 10 students, taught by an experienced professional, is hard to come by. One of the aims of the 2004 IDEIA is to assure that such interventions are part of the pre-referral process. Until these goals are reached, special education eligibility will be the royal road to competent small group instruction for severely academically delayed students. If the IEP team receives documentation that a processing disorder can be identified, the likelihood that the student receives such help is greatly increased.

There is of course much informal and some scientific evidence about the relationship between processing weaknesses and academic performance. This will be presented in the discussion to follow.

What do psychological processes have to do with learning disabilities or LD? Since they are assumed to underlie learning and academic achievement in general, "Why aren't processes also associated with genius or mental retardation?" you may ask. Yes, a very good question the answer to which is historical/political/emotional and not logical. To give an answer we must go back to the "discovery" of learning disabilities.

The expression Learning Disabilities was first used by Samuel Kirk in 1963 at a conference of teachers and parents of "perceptually handicapped" children. Kirk's definition of learning disabilities was incorporated into special education law where it still remains.

> *Recently I have used the term "learning disabilities" to describe a group of children who have disorders in development in language, speech, reading, and associated communication skills needed for social interaction. In this group I do not include children who have sensory handicaps such as blindness or deafness, because we have methods of managing and training the deaf and the blind. I also exclude from this group children who have generalized mental retardation.*

Traditionally the learning disability community has assumed that the children they are advocating for have average intelligence (or higher)…they are not retarded. There is then an unexplained or unexpected reason why certain kids can't learn. This thinking led to the idea of a significant discrepancy between intelligence and achievement as the defining characteristic of LD. There are good reasons why this definition was well received and lingers still. It is comforting to know that in spite of problems at school, the LD child or adult is basically intelligent. The discrepancy definition opens special education doors to students who are achieving near grade level provided they have high "ability". Students with lower I.Q., without a discrepancy, are less likely to show significant progress in a short period of time. Although the federal IDEA law has changed, the discrepancy paradigm will not readily go away.

The basic idea, influenced by information processing theory is that while "central" thinking and problem solving abilities, (abstract, fluid reasoning and concept formation) are OK (the child behaves intelligently outside of school and is often described as "smart"), there are hang ups, or blockages in the way information gets in, out of, and is stored by the brain. The LD child is deficient in a specific process or area, rather than in a general or global way. Specific is the key word in identifying the processing disorders assumed to underlie learning disabilities. In the early work, sensory-motor and perceptual processes were emphasized. Currently, the notion of working memory is a heavily used explanatory construct. Specifically, what might be deficient in an LD child if he/she is basically smart?

Visual or auditory processes, the most common sensory pathways to central processing, could be at fault.

How does the information get moved into long term storage (our memory bank)? How can this information get out again? Memory and retrieval processes may be faulty.

How can the child express what he/she has learned? Maybe there is a block between head and hand (sensory-motor functioning), or, between brain and mouth. (Speech or language problem)

Maybe the in and out connections are just functioning very slowly (processing speed).

It's perfectly plausible to conceive of giftedness or mental retardation as the result of the combined action of a number of specific processes including those involved in fluid reasoning and verbal comprehension. This is where the labels "abilities" and "processes" overlap. But historically, the term "psychological processes" has been most often used to explain what is wrong in a learning disabled (LD) individual.

We will now describe specific processes and how they can best be assessed. As a matter of convenience and because this classification still appears on IEP documents, the five psychological processes enumerated by the prior state regulations will form the basis of this discussion.

To review, these are: Attention
Visual Processing
Auditory Processing
Sensory-Motor Skills
Cognitive Abilities, including association, conceptualization and expression.

Tests of these processes may be included in intellectual ability batteries, or they may be assessed separately by special less inclusive tests such as the Bender-Visual-Motor Gestalt Test, Comprehensive Test of Phonological Processing or Wide Range Assessment of Memory and Learning. The Woodcock Johnson III Tests of Cognitive Abilities are a collection of brief specific tests some of which measure reasoning and problems solving and others that resemble process specific tests. The newer versions of the heavy weights in intelligence testing, the Wechsler Tests, DAS –II, Stanford Binet 5, and KABC-II all include traditional

specific process tests; which ones depend on the proclivities of the test authors. (*Note: I am not familiar enough with the Stanford Binet, 5th edition to include it in the discussion to follow)*

1. **Attention**

Attention may be basic to all other processes. The ability to focus attention and concentrate is necessary for most learning and task performance. Usually, a disorder in this process can be directly observed in the classroom.

There are many aspects of attention, among them selective attention (the ability to screen out or inhibit irrelevant stimuli or thoughts), sustained attention (staying alert and vigilant) and divided attention, to be discussed under working memory below. R.A. Barkley, a leading expert in attention problems, believes that impaired inhibition of behavior underlies most attention/hyperactivity disorders.

"Poor listening skills, distractible, can't stay on task" are descriptions frequently used by teachers that might indicate that the student has an attention disorder. There may be other reasons for poor attention: lack of motivation, anxiety, other processing disorders that interfere with understanding and performance. Consequently, an attention disorder is seldom found in isolation. Most often, it would be described as an observed behavior in conjunction with other learning disabilities. Problems with auditory processing, especially short term auditory memory, are often confused with attention disorders.

A good indication of an attention disorder is the student's classroom behavior. Children with attention problems will be restless, fidgety, have difficulty focusing, organizing, and completing work. They may appear to daydream and "do nothing", or they may call out, constantly start conversations with others, or be up to sharpen their pencils every five minutes. School work is often incomplete, or done in rushed, impulsive manner. Students may be highly distracted by noises and activities in the classroom, or by their own thoughts.

These behaviors are often assessed by rating scales that systematically quantify the problematic behavior. The **Conners-3 and BASC-II** rating scales are recommended for a number of reasons: They were standardized on large samples, they contain "validity" scales which evaluate response sets and overly negative or positive responses, they provide forms for parent, teacher and self, they are age normed and separate hyperactivity/impulsivity from attention problems.
The BASC assesses a wide range of problems while the Conners scales focus on ADHD and closely related disorders.

Are there standardized direct tests of attention? Tests of continuous performance, requiring specialized computer programs, are not generally available to school psychologists. **The Attention Scales of the Cognitive Assessment System (CAS)** assesses resistance to distracters, visual vigilance, and the ability to hold an instruction in awareness and maintain focus. They need to be used with caution with learning disabled children because fine motor ability, visual discrimination, familiarity with numbers and color names, and "automatic processing speed" are also assessed by these Attention Scales.

The **NEPSY II: A Developmental Neuropsychological Assessment** combines tests of attention and executive function (to be discussed below).The revised version of the NEPSY is normed for ages 3-16. The 6 subtests in Attention and Executive Function Domain assess a number of diverse processes. However, two subtests Auditory Attention and Response Set and Inhibition give a good indication of the ability to attend, hold an instruction and inhibit a response.

The **Woodcock-Johnson-III Cognitive Battery** includes several subtests related to attention problems. All of these are brief and influenced by other processes which may be impaired in LD children. The W-J

III Broad Attention Cluster is composed of four subtests two of which measure aspects of working memory. Working memory is usually defined as the ability to hold information in immediate awareness while performing additional operations on it. The classic example is remembering the sequence of steps in long division while computing the necessary math facts. Card games such as bridge, which require the player to remember the cards played while plotting appropriate strategy, make high demands on working memory. Working memory has been related conceptually to attention because the person must simultaneously attend to both types of information without getting distracted.

The working memory subtests of the **W-J-III** are Numbers Reversed and Auditory Working Memory. Both rely heavily on short term sequential auditory memory. The two additional tests forming the Broad Attention Cluster are the Auditory Attention subtest which asks the listener to identify speech sounds with increasing background noise, and a paper and pencil test, and Pair Cancellation, which assesses persistence and the ability to remember a simple instruction. Pair Cancellation requires good visual discrimination and Auditory Attention assumes normal hearing and normal auditory processing. It is included as a test of attention because it does require the ability to inhibit responding to the distracting noise.

Use these tests with great caution and examine them individually rather than relying on the broad cluster score which may wash out specific subtest highs and lows that could be of diagnostic importance.

The newly revised **Wide Range Assessment of Memory and Learning (WRAML 2),** now contains an Index labeled **Attention-Concentration.** However, the subtests involved, Number-Letter and Finger Windows, are essentially measures of short term verbal and spatial memory. Their use as an attention measure is not recommended.

Executive Functions: The abilities to choose to which stimuli to attend, inhibit responding to distracting circumstances, and plan ahead in a goal directed manner have been termed executive functions and are closely related conceptually to attention. Executive functions also include self monitoring, and "meta cognition"…deciding which cognitive strategy is the best to use in various circumstances. Many researchers believe that these abilities are mediated in part by the orbital-frontal cortex and develop gradually as the child matures. In order to assess executive processes, specific paper and pencil tests of planning ability have been developed. The **Cognitive Assessment System (CAS)** contains three planning tests which require good visual discrimination and visual scanning, sensory-fine motor speed, and the ability to develop a spatial strategy. These subtests are standardized variations of informal neuropsychological tests long used to assess "brain damage".

The Woodcock-Johnson III Cognitive battery has an **Executive Processes Cluster** which includes two paper and pencil test, Planning and Pair Cancellation that also requires good visual scanning ability. The other subtest included in the Executive Function cluster is Concept Formation, a test of fluid reasoning which also assesses the response set rigidity associated with frontal lobe deficits.

The Delis-Kaplan Executive Function System (ages 8 to 89) is the standardized descendent of older neurological tests, used primarily with adults. The Trail Making subtest assesses the ability to hold both number and letter order in mind simultaneously (working memory). Ability to inhibit verbal responding is measured by the Color-Word Interference Test. The remaining seven subtests evaluate the deficits in fluency, flexibility, problem solving and inhibition associated with acquired brain injury to the orbital-frontal region. The relationship of these abilities to the problems of the attention disordered student you are likely to see is not well understood.

Included in the **NEPSY II,** under the domain of Attention and Executive Functioning, is the Animal Sorting subtest which assesses the abilities to form concepts, sort into categories and shift set from one concept to

another. Sorting tasks have long been used to assess adults with frontal acquired brain injury, the presumed seat of executive functioning

Most of the Attention and Planning tests ask students to concentrate for a few minutes only. It is quite possible for a child with a serious attention disorder to be able to focus on novel material for a brief period of time in a quiet one to one setting with an encouraging adult.

Must Remember: There are many underlying issues that may cause a student to display attention disorder symptoms. The most common in young children are difficulties in comprehension, memory and learning which cause the child to appear inattentive, or which may generate distractible, off task behaviors as the child attempts to avoid the unpleasant learning situation. Evaluate LD, especially language delays, poor auditory memory and early reading difficulties before specifying attention as the source of the problem. Emotional concerns, notably anxiety and depression contribute heavily to attention problems and should also be evaluated.

- DO NOT CONFUSE IDENTIFYING A PROCESSING DISORDER IN ATTENTION WITH A DIAGNOSIS OF ADHD. If the psychologist can document that difficulty in attending is the source of poor academic achievement, he/she can identify an attention processing disorder. This may or may not lead to a formal ADHD diagnosis.

2. Visual Processing (Also known as visual-spatial processing.)

Disorders in visual processing interfere with a student's ability to interpret, discriminate and organize visual information. Difficulties with directionality, matching, spacing, appreciation of size, figure-ground and part-whole relationships are found in students with visual processing disorders. Remembering what things look like, being able to find your way around the school, drawing and mechanical ability are all related to visual processing. The inability to grasp non-verbal social cues may be a form of a visual processing deficit. Weakness in visual processing are assumed to underlie some of the symptoms of the non-verbal learning disabilities syndrome.

Visual processing difficulties are most important in the school performance of young children. Letter reversals, poor letter discrimination, irregular spacing in writing , problems with left right direction in reading and writing, difficulty lining up arithmetic computation problems may be caused by visual processing disabilities. Letter reversals and poor letter identification (as opposed to discrimination) may be symptoms of phonological problems that have led to difficulties in linking letters with their corresponding sounds.

Visual processing disabilities become important again in the upper elementary and secondary curriculum, where they can interfere with complex math (especially geometry) and science achievement.

The **Motor Free Visual-Perception Test,** the **Test of Visual-Perceptual Skills (Gardner),** the visual portion of **the Developmental Test of Visual-Motor Integration (VMI)** and the **Bender-Gestalt II Perception test** are measures of the kind of visual processing weakness that interferes with early academic achievement. The Jordan Left-Right Reversal test is not well standardized but is sometimes useful in documenting a letter reversal problem.

Complex visual processes are assessed by the non-verbal parts of global intelligence tests. The **Visual-Spatial Thinking Factor of the Woodcock-Johnson III Cognitive** assesses the aspect of visual processing believed to be associated with higher math and science success. The subtest **Spatial Relations** taps the ability to visualize and mentally manipulate abstract shapes in space, while **Picture Memory,** assesses the ability to recognize what has just been seen.

Visual spatial ability plays a large role in **the WISC IV Perceptual Reasoning Index.** Of the three subtests, **Block Design, Matrix Reasoning, and Picture Concepts**, Picture Concepts appears to have an implicit verbal reasoning component, while Matrix Reasoning is very similar to tests which appear as part of a fluid reasoning domain in other test batteries. **Block Design** is probably the best measure of the kind of visual ability associated with good mechanical and artistic skills.

The **KABC-II** includes a **Visual Processing or Simultaneous Processing Index.** The concept of Simultaneous Processing comes from the neuropsychological theory of A.R. Luria and is defined as the ability to integrate various stimuli into a whole. This integration is easily applied to visual stimuli, and the process is often assessed by spatial visualization tasks. The KABC II contains Triangles and Block Counting subtests of visual processing. The Visual/Simultaneous Index also includes the Rover subtest, a complex test requiring planning and good impulse control as well as spatial visualization, and is not the best task by which to assess visualizing ability.

The **NEPSY II** Visuospatial Domain contains six subtests measuring attention to visual detail, mental manipulation, and analysis of visual material. While many of these abilities are covered by global intelligence tests, the **NEPSY** visual tests may be useful in specific diagnostic assessments such as identifying a non-verbal learning disorder.

Visual memory is considered to be part of visual processing. The **Visual Memory Index of the WRAML-2** especially the Picture Memory subtest, yields good assessments of visual memory. The Design Memory subtest requires the student to copy a complex design from memory and thus involves fine motor ability. So does the Recall of Designs subtest from **the Differential Ability Scales –II**. (DAS). The Memory for Designs subtest of the **NEPSY II** assesses spatial memory as well as memory for visual detail. Use of a "memory grid" and cards avoids fine motor issues.

Is visual memory, as assessed by the tests described above, related to spelling and remembering "sight" words in reading? The answer is **No, No, No, and No.** Students with reading/spelling disabilities often have strong visual memories (especially for layouts, pictures, and overall gestalts). Visual memory alone, when not interfacing with the brain's language systems, is not a factor in the ability to spell or read fluently. We do not yet understand what enables some people to "visualize" words. The ability to recall familiar letter sequences is mediated by processes that are different from those involved in recalling non linguistic, representational or abstract visual information.

3. Auditory Processing

Auditory processing disorders in students with adequate hearing acuity manifest themselves in poor ability to discriminate, decode, encode, remember and interpret speech sounds. (Music and environmental sound perception will be excluded from this discussion, because weakness in these areas rarely impacts achievement in basic skills) Poor auditory processing is often associated with a speech or language disorder, but it also includes those phonological processes important in the decoding aspects of reading, such as manipulating speech sounds. An auditory processing weakness may make it difficult for a student to screen out background sounds in a noisy classroom, and will interfere with the tracking, remembering, and comprehension of auditory directions and oral learning presentations.

Test results should be corroborated with observations of the student's auditory difficulties. Does the student tune out, misunderstand directions, follow only one or two directions, frequently ask what to do, ask the teacher to slow down when he/she is dictating words or sentences? Can the young child rhyme and play with the sounds of words? Does mis-hearing or tuning out occur even when the student appears to be paying attention?

Tests that claim to measure auditory processing vary widely in their content because the definition of this ability is very elastic. Tests range from a specific assessment of central auditory processing (SCAN) which measures auditory figure/ground perception and the ability to resolve conflicting information from each ear, to tests of language comprehension with item content similar to the verbal part of global intelligence tests. Auditory processing problems are among the most frequently identified of all processing disorders, and often are the inferred processing disorder in reading disabled students.

Auditory memory appears to be an integral part of auditory processing, as language is by definition sequential. Remembering bits of information in the right order is essential to decoding speech, and since the sounds that make up speech are delivered so rapidly into the language system, speed is crucial. Mixing up the order of sounds is probably the result of a specific kind of slow processing speed. Limited auditory processing speed severely impacts short term memory which in turn influences storage in long term memory, semantic organization and retrieval.

Problems with word retrieval are often noted in speech and language evaluations. Word retrieval issues are of great importance in much written and oral expression. Look for word retrieval or word finding difficulties in children who talk around a subject, use non-specific words such as "thing" and "stuff" and show signs of the "tip of the tongue" phenomenon. The **Woodcock-Johnson III Cognitive,** Retrieval Fluency subtest asks the student to recall proper names, foods, and animals as quickly as possible. (Note: This subtest is grouped with Visual-Auditory Learning to form the **Long Term Retrieval Factor**; but these two tests assess very different specific abilities). There is a new standardized test used by speech therapists to assess word retrieval problems, and the **NEPSY II** also contains a retrieval fluency subtest, Word Generation. Word retrieval can be conceptualized as one aspect of retrieval from long term memory.

Speech/language evaluations can be very helpful in identifying auditory processing deficits. The **LAC test**, the diagnostic instrument used with the Lindamood LiPS program is a useful measure of auditory processing abilities important in beginning reading, though not well standardized. **The Clinical Evaluation of Language Functions (CELF-R),** frequently given by speech therapists, assesses many aspects of language and auditory processing.

Psychological tests of auditory processing include the **Auditory Processing Cluster of the Woodcock-Johnson III Cognitive** battery, and the **Test of Auditory Processing Skills, 3rd edition (TAPS-3).** The Woodcock-Johnson Auditory Processing Cluster consists of a test of Sound Blending, and the Auditory Attention subtest described in the Attention section. Scores on these subtests are often not related in children who have had phonics training, and the two subtests should be considered separately. The Woodcock-Johnson Sound Blending subtest almost invariably produces inflate scores.

The **TAPS-3** was recently standardized on a large, national sample, although the sample was not representative and required extensive use of weights to develop the test norms. The **TAPS** now includes three Indexes assessing Phonological Skills, Memory (to be discussed below) and Auditory Cohesion. Auditory Cohesion tests literal and inferential language comprehension and is similar to the oral language achievement tests in global achievement batteries.

Phonological processing, or the ability to encode and decode speech sounds, is a form of auditory processing now assumed to be one of the core deficits in reading disabilities. The **Comprehensive Test of Phonological Processing (CTOPP**) assesses Phonemic Awareness, Phonological Memory, and Rapid Naming, all associated with success in early reading. Rapid Naming may or may not be a phonological process; it can be considered a mini model of the many abilities involved in reading, for which speed is critical. Note that Rapid Naming is grouped with the Speed of Information Processing to form the Processing Speed Diagnostic Cluster of the DAS-III.

Phonemic awareness is best considered a part of phonological processing; most phonemic awareness tests are labeled phonological processing in the current tests batteries. The most commonly used definition is the ability to discriminate, analyze and manipulate speech sounds; sound/symbol connections (letters) are not involved. Phonemic awareness tests require the child to rhyme, identify syllables, delete and manipulate sounds and blend individual sounds together to make words. These skills are assessed in global achievement batteries as well as by more specific process tests. You now can choose from a large number of phonemic awareness tests included in the **CTOPP, TAPS-3, Woodcock-Johnson III, Achievement Battery, Kaufman Tests of Educational Achievement (KTEA-II), DAS II** Diagnostic Tests**, and NEPSY.II (**Language Domain**).** The Woodcock-Johnson Cognitive Phonemic Awareness Cluster assesses somewhat different skills and is not recommended. The phonemic awareness tests available in the TAPS-3, DAS-II and NEPSY II, are more recently standardized than the CTOPP whose norms are now ten years old.

In my experience, sound deletion tasks are more difficult for students than sound blending, which is taught directly in pre-reading instruction. The ability to manipulate sounds appears to be a better predictor of reading problems than sound blending; therefore look carefully at individual subtests before drawing conclusions from phonemic awareness cluster scores.

There are many tests of immediate short term auditory memory or memory span and few that include measures of delayed recall. Auditory memory span is measured by the **Short Term Memory (Sequential) Index** of the **KABC-II**, and the **Successive Scale** of the **Cognitive Assessment System (CAS).** Specific process tests of short term auditory memory are included in the **CTOPP**, (as an aspect of phonological processing) the **TAPS-3** and the **WRAML-2**. The **WRAML** tests many aspects of short term and delayed memory, both visual and verbal and is considered to be a useful test in identifying auditory memory problems. Remember that only verbal memory can be considered a part of auditory processing.

Working Memory. We discussed the construct of working memory in relation to attention and executive function…because working memory requires holding one thing in mind and applying it to another. It often involves divided attention and retrieval from long term memory. However, most of the actual tests of working memory rely heavily on short term auditory memory, requiring the student to re-arrange bits of newly acquired information. While these tests may be factorially distinct from simple short term memory measures, they fail to include the more complex aspects of working memory, such as long term retrieval and response inhibition, important in academic learning. The **Woodcock Johnson Cognitive III** Working Memory Cluster, the **Working Memory Index of the WISC-IV**, and **Working Memory Index of the WRAML-2 ,** can be folded into the "auditory processing category" if the need arises. Another possibility is to classify these working memory weaknesses as the association aspect of a cognitive processing disorder. Remember that according to prior state criteria, a disorder in cognitive abilities includes association, conceptualization and expression. Or, if psychologists are no longer bound by the traditional processing categories, a memory deficit can be identified.

Long Term Retrieval. We have already discussed long term retrieval in relation to word finding problems. Both the **Woodcock-Johnson Cognitive** and the **KABC II** include tasks of visual-verbal associative learning labeled long term retrieval. For the **KABC**, these are the Atlantis and Rebus subtest forming the **Long Term Retrieval or Learning Inde**x. The **Woodcock** Visual-Auditory Learning subtest is quite similar. However, its partner in the Long Term Retrieval Factor, Retrieval Fluency, taps speed of word retrieval rather than memory. Atlantis, Rebus, and Visual-Auditory Learning should be used with caution as they do not really assess the long term consolidation required to store information in long term memory. The "delay" condition for these tests works best for the Woodcock-Johnson where a delay of up to 8 days is permissible. It is this "really long term" memory weakness which seems to be at the heart of many students' learning problems. Using the old state of California regulations, both visual and auditory

processing could be identified if a Visual-Auditory Learning weakness was found. As with working memory "association" is another possibility, and if process identification becomes more flexible, go with a memory deficit.

4. Sensory-motor abilities

Preschool age children have difficulty copying letters due to the immaturity of their neuromuscular system. By age seven, most children have the ability to make the horizontal, vertical, and angular lines, circles, squares, triangles, half-circles (rotated in different directions), intersecting lines and hooks used in forming letters. If these abilities do not develop normally in the kindergarten and early elementary years, the child becomes unable to produce the extensive amount of written work required in school. Aside from difficulties in writing, some children are also unable to hold a pencil properly, or they may be able to copy letters accurately, but with very shaky line quality.

Older children with sensor-motor difficulties may write legibly only with great effort, demonstrated by a tight pencil grip, heavy lines, large script, poor body posture, constant postural changes, or positioning the paper or workbook at an unusual angle. They may work very slowly with many erasures, or the project may be finished but almost illegible. Some older children are very resistant to learning cursive writing, and rely on printing for the rapid note taking important in the upper grades.

The **Bender Gestalt II** and the **Developmental Test of Visual-Motor Integration (VMI)** are the most widely used instruments for evaluating sensory-fine motor functioning. Both the VMI and the Bender Gestalt now include separate visual and motor tests, as well as the original copying tasks. The Bender-Gestalt-II has been recently re-standardized on a large national sample and its age range increased (up to age 89). A global scoring scheme is used. Note that the Bender vs. VMI correlation is only .65; they are measuring somewhat different processes. Adaptive physical education teachers and occupational therapists also give tests of fine (and gross) motor development.

It is wise to take a handwriting sample along with formal visual-fine motor tests. Better yet, obtain a sample of in-class written work. The Bender and VMI tests do not always predict handwriting ability. Furthermore, some children can be marvelous "artists", making elaborate and imaginative drawings, but lack the abilities required to copy complex material accurately. The Alphabet Writing and Copying subtests of the **Process Assessment of the Learner (PAL II)** give an assessment of handwriting fluency.

Is it visual or is it motor? This question may not be worth asking. The crucial break down may be in those parts of the brain that require integration of visual stimuli with motor acts. Motor planning, the ability to respond quickly to visual information and sensory feedback from muscles, is all important in sensory motor development. The **NEPSY II** includes a number of tests that assess the processing of sensory information by techniques traditionally used in neurological examinations, as well as a design-copy

Processing speed is a complex dimension which does appear to be related to the presence of specific learning disabilities. Tests which measure processing speed usually require the rapid discrimination of visual information combined with simple/automatic cognition and an accurate motor output. Short term memory may also be involved. The Coding subtest of the **WISC-IV** is believed to be a measure of processing speed. Sometimes the Coding subtest will be the only low score in a learning disabled child's test profile. It measures something significant but we don't know quite what. The Symbol Search subtest, which combines with Coding to form the **WISC-IV Processing Speed Index,** is often at an average level in children with reading disabilities, so beware of looking at the Index score only.

The Woodcock-Johnson III Processing Speed Cluster can also be used to evaluate processing speed. Again, beware of using only the combined Cluster score. The two subtests involved, Visual Matching and

Decision Speed probably make different demands on language and visual systems. Decision Speed, Retrieval Fluency and, Rapid Picture Naming are grouped to form a **Cognitive Fluency Cluster**. While there is yet little clinical or empirical information available about this cluster, it may well turn out to be useful in identifying a processing disorder in an LD student. (Note: In the writer's experience, Decision Speed is the outlier in the **Cognitive Fluency Cluster**; it assesses something different than the rapid verbal retrieval required by Rapid Picture Naming and Retrieval Fluency)

Processing speed was not classified as a separate dimension in the old California state regulations. If these categories are still required, the psychologist will have to use best judgment as to which processes to identify when a processing speed weakness is found.

What shall we do with Rapid Naming? Tests of rapid naming ask the student to quickly say the name of something he/she sees; either colors, letters, numbers or pictures. Weakness in rapid naming has been associated with difficulties in acquiring automaticity/fluency and decoding accuracy in reading. Research has shown that the motor aspects of speech do not account for variability in these tests. Speed of retrieval from long term verbal memory is probably involved. Rapid Naming is sometimes the only identified cognitive weakness in a child with reading delays. There are tests of rapid naming in the **CTOPP**, included as an aspect of phonological processing. Rapid Picture Naming is part of the **Woodcock Cognitive Fluency Cluster** as indicated above. The **DAS-II** includes a test of rapid naming of colors, pictures, and finally both at once. As noted above, the DAS groups Rapid Naming with Speed of Information Processing to form a Processing Speed Diagnostic Cluster. Note that the correlation between these two subtests is extremely modest. Rapid naming of colors, size, shapes and mixed letters and numerals is required by the **NEPSY II** Speeded Naming subtest, part of the Language Domain.

Because the essence of rapid naming appears to be retrieval speed of automatic, over-learned verbal responses, it could be regarded as an aspect of Processing Speed. Auditory processing is another possibility. If you are not bound by traditional special education categories, why not just call it a "Speeded Naming" weakness?

5. Cognitive Abilities

At first sight a specific processing disorder in cognitive abilities sounds like an oxymoron. Are not the constructs "cognitive ability" and "intellectual ability" often used interchangeably? Couldn't all the processes described above be called cognitive processes? The inclusion of the words "association," "conceptualization," and "expression" in the old education code eases the dilemma a bit. If a student has average or strong rote learning, visual-spatial, and sensory -fine motor abilities, but is weak in verbal comprehension and math reasoning and is "off topic" in oral discussion, there may be "specific" learning weaknesses in the abilities to generalize, draw logical conclusions and comprehend abstract relationships.

Students with "cognitive" processing weaknesses will have a hard time writing a good paragraph or giving the main idea of a reading selection. They may get lost in detail, be able to do computational arithmetic but be at a loss when confronted with "story problems" in math. These students are often described as "hands on" learners, and may be kind and helpful in the class room.

Because the processes described as "cognitive" are often thought of as the heart of general intelligence, cognitive processing disorders need to be assessed by global cognitive batteries. Tests of verbal comprehension and subtests such as Similarities from the **WISC-IV** are assumed to assess conceptualization and association. The **Woodcock Johnson Cognitive III** provides a useful way of identifying a disability in cognitive processing. The Fluid Reasoning and Comprehension/Knowledge Clusters assess the kinds of abilities associated with association, conceptualization and expression. Fluid

Reasoning consists of two subtests that measure concept formation and logical thinking directly, while requiring minimal prior knowledge.

INTERPRETING TEST SCORES
What does a low score on these process tests mean? Nothing, until you consider the following.

First of all remember that a low score on any one subtest or factor, coming from just a little test and not a great big global battery, is by its nature somewhat unreliable. If possible back up the finding with a similar test. This isn't always possible as your time is limited and your testee may be nearing exhaustion. Do look for corroborating non-test evidence. Parent/teacher interviews, direct classroom observation, work samples, and curriculum based assessments should provide good information about a students' learning strengths and weaknesses. The IDEIA regulations require that decisions be made on the basis of more than one assessment process.

Second, if you are identifying a processing weakness or disorder, make sure it is linked to an academic/achievement deficit. Otherwise what ever your low processing score might suggest, the obtained deficit is not interfering with academic functioning and can hardly be called a "disorder". You will be surprised how many people are walking around successfully with rather dismal scores in a process or two. You can still discuss the pattern, noting that the student has developed strategies to compensate for apparent weaknesses.

Note the following hypothesized relationships, which do have some research confirmation: Auditory processing is assumed to underlie language abilities and some form of it will be low in students with reading/spelling/writing delays. Visual processing and fluid reasoning are believed to underlie achievement in advanced math and science. Sensory motor lags can affect handwriting, written work in general, and performance in art classes. Problems with attention can show themselves in all curriculum areas, but especially where students are expected to be quiet, listen, and work independently. If a student has done well in the early grades, but is falling behind in a challenging secondary curriculum, look for difficulties in the areas associated with general intelligence: language comprehension and fluid reasoning. (There are many other reasons why secondary students have academic problems)

How low does a test score need to be before it suggests a processing disorder? There is little agreement here. A recent text, Milton Dehn, *Essentials of Processing Assessment,* (2006), advises use of a double barreled criterion. The score should be at least 15 standard score units (1 standard deviation) below the overall mean of all processing tests given, and below a standard score of 90. Thus both personal and normative scores need to be low. Similar criteria can be used to define personal and normative strengths and assets.

Use of deviations from an overall personal mean implies that if most scores are low, there is no processing problem. Aside from making little sense, this can lead to the exclusion of very needy individuals from special services. I recommend using a Standard Score below 85 (1 standard deviation) as a strong indicator of a processing disorder if backed up by additional observations and achievement testing. *This is controversial; not all will agree.*

Be very careful when comparing scores from different tests. This is essentially a cross battery approach and it is important to use well standardized, recently normed tests whenever possible. Average raw scores on most psychological tests have a tendency to creep up over the course of time, so try to avoid comparing scores from tests normed more than ten years apart. Fortunately you now have a plethora (a very large amount) of recently revised tests from which to choose. Armed with the knowledge presented here you can go forth to battle with process evaluation with courage and confidence.

RE-EVALUATION

PSYCHO-EDUCATIONAL RE-EVALUATION

[DATE OF REPORT]

NAME:	SCHOOL:
BIRTH DATE:	GRADE:
ASSESSMENT DATES:	TRACK:
AGE:	TEACHER:
PRIMARY LANGUAGE:	EXAMINER:

REASONS FOR REFERRAL

Name was referred for testing as a part of a three-year re-evaluation. This testing is designed to help determine (a) if **Name** continues to have a disability, (b) if **s/he** continues to need special education, (c) to document present levels of functioning and educational needs, and (d) to determine if additions or modifications to the special education program are needed.

PSYCHOLOGICAL PROCEDURES

From a review of prior assessment data, behavioral observations, teacher report, and input from **Name**'s parents, the following procedures were selected in order to address the reasons for referral:

BACKGROUND INFORMATION

Name is a (**grade**) grade (**gender**) who attends **School**. Currently, **s/he** receives (**List special education services as specified in the IEP**). The rational for this placement as stated on **Name**'s current (**date of IEP**) Individualized Education Program (IEP) is as follows: "(**Report the rationale for services as stated on the IEP**)." Current teacher reports indicate (**Discuss progress toward annual goals as reported by teachers**). For additional background information, including developmental and health history, the reader is encouraged to refer to the prior evaluations dated (**date of last evaluation**).

PREVIOUS EVALUATIONS

Name was previously assessed on (**Date of previous testing**) by (**Examiner**). Results suggested (**Brief summary of results**). Academic progress as measured by prior individually administered achievement testing is summarized in the following table of standard scores (mean, 100; standard deviation, 15):

Test	*Date*	*Date*	*Date*
Reading			
Arithmetic			
Written Language			

BEHAVIORAL ASSESSMENT

Behavior Ratings

Behavioral Observation

Test Taking Behavior

PSYCHOMETRIC ASSESSMENT

Intellectual Ability

Academic Functioning

Basic Psychological Processes

Social and Emotional Functioning

SUMMARY AND EDUCATIONAL IMPLICATIONS

Name is a (**CA**) (**Grade**) grade (**Gender**) who has been assessed as part of **his/her** legally mandated re-evaluation. Current assessment data suggests **Name**'s (**summarize data reflecting present levels of functioning**).

From the available data it is concluded that **Name does/does not** continue to have a learning disability. (**Summarize the data used to reach this conclusion**). The following recommendations address **Name**'s current learning needs.

1. **Name does/does not** continue to meet eligibility criteria as a student with (**Identify the appropriate special education eligibility classification and summarize the data that supports the eligibility conclusion**).

2. Specific special education placement and service recommendations include (**From the available data specify your placement/service recommendation**).

3. Additional recommendations designed to ensure **Name**'s success in the least restrictive educational environment.

4.

The final decision as to whether or not **Name** meets special education eligibility will be made by the individualized education program team, including assessment personnel, and will take into account all relevant material which is available on **Name**. No single score or product of scores, test or procedure has been used as the sole criterion for the decision of the individualized education program team as to **his/her** eligibility for special education.

_____

Stephen E. Brock, Ph.D., NCSP
Licensed Educational Psychologist

30 EC 56381 - REASSESSMENT OF PUPILS; TRIENNIAL

(a) A reassessment of the pupil, based upon procedures specified in Article 2 (commencing with Section 56320) shall be conducted at least once every three years or more frequently, if conditions warrant a reassessment, or if the pupil's parent or teacher requests a reassessment and a new individualized education program to be developed. If the reassessment so indicates, a new individualized education program shall be developed.

(b) As part of any reassessment, the individualized education program team and other qualified professionals, as appropriate, shall do the following:

(1) **Review existing assessment data** on the pupil, **current classroom-based assessments and observations,** and **teacher and related services providers' observations**.

(2) **On the basis of the review conducted pursuant to paragraph (1), and input from the pupil's parents, identify what additional data, if any, is needed to determine**:

(A) **Whether the pupil continues to have a disability** described in paragraph (3) of Section 1401 of Title 20 of the United States Code.

(B) The **present levels of performance and educational needs** of the pupil.

(C) **Whether the pupil continues to need special education** and related services.

(D) **Whether any additions or modifications to the special education and related services are needed** to enable the pupil to meet the measurable annual goals set out in the individualized education program of the pupil and to participate, as appropriate, in the general curriculum.

(c) The district, special education local plan area, or county office shall administer tests and other assessment materials as may be needed to produce the data identified by the individualized education program team.

(d) If the individualized education program team and other qualified professionals, as appropriate, determine that no additional data is needed to determine whether the pupil continues to be an individual with exceptional needs, the district, special education local plan area, or county office shall notify the pupil's parents of that determination and the reasons for it, and the right of the parents to request an assessment to determine whether the pupil continues to be an individual with exceptional needs; however, the district, special education local plan area, or county office shall not be required to conduct an assessment unless requested to by the pupil's parents.

(e) A district, special education local plan area, or county office shall assess an individual with exceptional needs in accordance with this section and procedures specified in Article 2 (commencing with Section 56320) before determining that the pupil is no longer an individual with exceptional needs.

(f) No reassessment shall be conducted unless the written consent of the parent is obtained prior to reassessment except pursuant to subdivision (e) of Section 56506.

TEMPLATE FOR GF-GC REPORT

The following template provides an alternative means of interpreting cognitive testing. It should be used in conjunction with the subtest grouping worksheet that is available at Institute for Applied Psychometrics webpage or in McGrew, *The Intelligence Test Desk Reference.*

It takes the place of the more traditional method for reporting cognitive functioning. Sample reports are available in report binder in office.

Cognitive Functioning:

- If doing a Gf-Gc analysis you may wish to first discuss the general cognitive assessment in terms of that particular test. Below is an example with DAS.

  The Differential Ability Scales (DAS) was given to Sara as a general measure of a variety of different cognitive processes. The DAS is a standardized test designed to provide information on general conceptual skills as well as on specific cognitive abilities. Sara completed the 6 core subtests which are grouped together to form composite scores as well as yield a General Conceptual Ability Score (GCA). The GCA score should be considered a composite of the three separate domains of cognitive functioning that are measured by the Cluster Scores. In addition to the GCA and Composite Scores, Sara's performance on the individual subtests is useful in evaluating specific cognitive skills.

  Sara's General Conceptual Ability score of 98, computed from her performance on the DAS, places her in the average range (45th percentile) compared to other children her age. Her Nonverbal Reasoning and Spatial Cluster Scores are also in the average range and fall at the 63rd and 50th percentiles, respectively. Her Verbal Reasoning Cluster Score of 92 is also within the average range and falls at the 30th percentile.

- Then you may start Gf-Gc interpretation

The results of cognitive testing were considered together via cross-battery principles and procedures to yield seven broad cognitive ability clusters including: fluid reasoning (Gf), crystallized intelligence (Gc) visual processing (Gv), short term memory (Gsm), long term retrieval (Glr) auditory processing (Ga) and processing speed (Gs).

Cross-Battery Assessment of Fluid Reasoning (Gf). Fluid reasoning can be described as the ability to reason, form concepts, and solve problems using unfamiliar information or novel procedures. The subtests used to measure Gf assessed Sara's ability to detect patterns in both figural and numerical material. Sara displays average fluid reasoning ability (broad ability SS = 106).

Cross-Battery Assessment of Gc. Crystallized Intelligence (Gc) is a broad ability that involves an individual's breadth and depth of general and cultural knowledge, verbal communication, and reasoning with previously learned procedures. The subtests that are seen to measure Gc assessed Sara's knowledge of word meaning, verbal reasoning and verbal knowledge. Sara received a Broad Ability rating in the average range (SS = 100). Her language development, ...Her listening comprehension, ... her lexical knowledge.....

Cross-Battery Assessment of Gv. Visual Processing (Gv) is defined as the ability to analyze and synthesize visual stimuli and involves perceptions and manipulations of visual shapes and forms, usually when figural or geometric in nature. Sara's Visual Processing skills are within the average range (SS = 101). Her ability to perceive and mentally manipulate visual patterns .... Her memory for visually presented material .....

Cross-Battery Assessment of Gsm. Short-term memory (Gsm) is the ability to hold information in immediate awareness and then use it within a few seconds. Sara's Gsm ability was assessed through tasks that ..... Sara's overall short-term memory is at the low end of the average range (SS = 91). Her memory for verbal and visual material was .....

Cross-Battery Assessment of Glr. Long-term storage and retrieval (Glr) is the ability to store information and fluently retrieve it later through association. Sara's overall long-term storage and retrieval skills fall within the average range (SS = 104). However, her performance across subtests that measure various aspects of long-term storage and retrieval showed considerable variation.....

Naming facility is considered a component of long-term retrieval....

Cross-Battery Assessment of Ga. Auditory Processing (Ga) is the ability to analyze and synthesize auditory stimuli. Sara's auditory processing ability was assessed through tasks that required her to integrate verbally presented syllables and/or phonemes into real and nonsense words (Blending Words SS = 100, Blending Nonwords SS = 100) and to segment real and nonsense words into their constituent sounds (Segmenting Words SS = 100, Segmenting Nonwords SS = 100).....

Cross-Battery Assessment of Gs and Gt. Processing Speed (Gs) is defined as one's ability to quickly perform automatic cognitive tasks. On simple speed tasks requiring focused concentration, Sara performs within the average range. Decision Time (Gt) is the ability to quickly make simple decisions....

Attentional Processes. The Attention/Executive Function domain of the NEPSY was administered to assess attentional processes. In addition, portions of the BASC target behaviors indicative of ADHD

SAMPLE CROSS-BATTERY REPORT 1

Behavior During Testing:

Lucas was pleasant and easy to work with. His conversational proficiency was typical for his age and he freely engaged in discussion about a variety of topics. He was very cooperative throughout the examination. He appeared at ease, comfortable and attentive to the tasks. Lucas responded carefully to test questions, generally within an appropriate amount of time. He persisted with difficult tasks to an appropriate extent. The results of this evaluation can be considered accurate measures of his current level of functioning.

Current Testing:

Results of current and previous testing were considered together via cross-battery principles and procedures to assess relevant broad cognitive ability clusters. Therefore, selective testing was performed in order to supplement previous test results. The following tests were administered:

Woodcock-Johnson Tests of Cognitive Abilities-III (selected subtests)
Woodcock-Johnson Tests of Achievement-III (selected subtests)
Test of Word Reading Efficiency
Gray Oral Reading Test-R
Test of Written Language

The individual scores for these tests are presented at the end of this report. Like any such tests purporting to measure cognitive or intellectual abilities, it is important to remember that these scores represent a sample of Lucas's behavior.

Cross-Battery Assessment of Fluid Reasoning (Gf). Fluid reasoning can be described as the ability to reason, form concepts, and solve problems using unfamiliar information or novel procedures. The subtests used to measure Gf assessed Lucas's inductive and sequential reasoning ability. Lucas displays average fluid reasoning ability (broad ability SS = 99). On subtests assessing induction and sequential reasoning he received average range composites.

Cross-Battery Assessment of Gc. Crystallized Intelligence (Gc) is a broad ability that involves an individual's breadth and depth of general and cultural knowledge, verbal communication, and reasoning with previously learned procedures. The subtests that are seen to measure Gc assessed Lucas's knowledge of word meaning, verbal reasoning and verbal knowledge. Lucas received a Broad Ability rating in the average range (SS = 110). His language development, as measured by his ability to form verbal categories and to respond to verbal reasoning questions is within the average range (WISC-III, Similarities SS = 100, Comprehension SS=115). Lucas's lexical knowledge, as assessed by his ability to define words is also within the average range (WISC-III Vocabulary SS = 100).

Cross-Battery Assessment of Gv. Visual Processing (Gv) is defined as the ability to analyze and synthesize visual stimuli and involves perceptions and manipulations of visual shapes and forms, typically when figural or geometric in nature. Lucas's Visual Processing skills are above average (Cluster SS = 117). His ability to perceive and mentally manipulate visual patterns is strong (WISC-III SS = 115). His ability to combine disparate visual elements into a cohesive whole is above average (WISC-III Object Assembly SS=120).

Cross-Battery Assessment of Gsm. Short-term memory (Gsm) is the ability to hold information in immediate awareness and then use it within a few seconds. Lucas's Gsm ability was assessed through tasks that required him to immediately recall numbers in a given order, both forward and backward and to recall and rearrange verbally presented lists of numbers and words. Lucas's memory span was within the average

range (WISC-III Digit Span SS= 95). His working memory was at the high end of average (Narrow Ability Score = 114).

Cross-Battery Assessment of Glr. Long-term storage and retrieval (Glr) is the ability to store information and fluently retrieve it later through association. Lucas's overall long-term storage and retrieval skills fall within the average range (SS = 97). However, his performance across subtests that measure various aspects of long-term storage and retrieval showed variation. His ability to learn associations between unfamiliar visual and verbal information and his ability to rapidly produce a series of concepts or words were within the average range (WJ-III Visual- Auditory Learning and Retrieval Fluency). His ability to recall meaningful material presented verbally was also within the average range (WJ-III Story Recall). However, Lucas performed at the low end of average range on tasks of naming facility (WJ-III Rapid Picture Naming SS= 86, CTOPP Rapid Naming Composites SS= 88, 85).

Cross-Battery Assessment of Ga. Auditory Processing (Ga) is the ability to analyze and synthesize auditory stimuli. Results from a previous administration of The Comprehensive Test of Phonological Processing (CTOPP) were used to evaluate Lucas's auditory processing. Lucas's auditory processing ability was assessed through tasks that required him to integrate verbally presented syllables and/or phonemes into real and nonsense words and to segment real and nonsense words into their constituent sounds. These tasks primarily measured Lucas's ability to analyze the individual sounds in words (Phonetic Coding: Analysis) and synthesize such sounds (Phonetic Coding: Synthesis). Lucas performed within the average range on these tests (Phonological Awareness Composite SS=112, Phonological Memory Composite SS=109). Lucas does not demonstrate any difficulties in manipulating the sounds of language: a skill that is critical to the development of reading.

Cross-Battery Assessment of Gs and Gt. Processing Speed (Gs) is defined as one's ability to quickly perform automatic cognitive tasks. Decision Time (Gt) is the ability to quickly make simple decisions. On simple speed tasks requiring focused concentration and decision making, Lucas performs below the average range, overall. Though his simple rate of test taking is at the low end of the average range on other processing speed tasks he is below average (SS= 76). Tasks that were difficult for Lucas required retrieving names or concepts and making a simple decision regarding the stimuli. Lucas works slowly when mental comparisons are required.

Cognitive Efficiency and Cognitive Fluency: Lucas's ability to process information automatically is within the average range (SS=97), however his fluency is well below average (SS=78). Therefore, though Lucas has access to automatic processing, he tends to perform cognitive tasks slower than others his age.

SAMPLE CROSS-BATTERY REPORT 2

Cognitive Functioning:

The Differential Ability Scales (DAS) was given to Michael as a general measure of a variety of different cognitive processes. The DAS is a standardized test designed to provide information on general conceptual skills as well as on specific cognitive abilities. Michael completed the 6 core subtests which are grouped together to form composite scores as well as yield a General Conceptual Ability Score (GCA). The GCA score should be considered a composite of the three separate domains of cognitive functioning that are measured by the Cluster Scores. In addition to the GCA and Composite Scores, Michael' performance on the individual subtests is useful in evaluating specific cognitive skills. Michael also completed one of the diagnostic subtests.

The Wide Range Assessment of Memory and Learning (WRAML) was also administered. This test provided information on Michael' verbal and visual memory as well as on his ability to learn over trials with both verbal and visual material.

The Comprehensive Test of Phonological Processing (CTOPP) was administered in order to provide more information regarding cognitive processes commonly associated with reading disabilities.

Portions of the NEPSY, a developmental neuropsychological assessment were administered to assess attention, executive functioning, and sensorimotor development.

The individual scores for these tests are presented at the end of this report. Like any such tests purporting to measure cognitive or intellectual abilities, it is important to remember that these scores represent a sample of Michael' behavior.

Michael' General Conceptual Ability score of 101, computed from his performance on the DAS, places him in the average range (53rd percentile) compared to other children his age. His Nonverbal Reasoning and Verbal Reasoning Cluster Scores are also in the average range and both fall at the 42nd percentile. His Spatial Cluster Score of 108 is also within the average range and falls at the 70th percentile.

The results of cognitive testing were considered together via cross-battery principles and procedures to yield seven broad cognitive ability clusters including: fluid reasoning (Gf), crystallized intelligence (Gc) visual processing (Gv), short term memory (Gsm), long term retrieval (Glr) auditory processing (Ga) and processing speed (Gs).

Cross-Battery Assessment of Fluid Reasoning (Gf). Fluid reasoning can be described as the ability to reason, form concepts, and solve problems using unfamiliar information or novel procedures. The subtests used to measure Gf assessed Michael's ability to detect patterns in both figural and numerical material. Michael displays average fluid reasoning ability (broad ability SS = 97). On subtests assessing induction, seqeuntial reasoning and quantitative reasoning he received average range composites, though his quantitative reasoning score is likely mildly deflated due to math computation weaknesses.

Cross-Battery Assessment of Gc. Crystallized Intelligence (Gc) is a broad ability that involves an individual's breadth and depth of general and cultural knowledge, verbal communication, and reasoning with previously learned procedures. The subtests that are seen to measure Gc assessed Michael' knowledge of word meaning, verbal reasoning and verbal knowledge. Michael received a Broad Ability rating in the low end of the average range (SS = 93). His language development, as measured by his ability to form verbal categories is high average (DAS, Similarities SS = 111). However, his lexical knowledge, as assessed by his ability to define words and to provide synonyms and antonyms to orally presented words, is in the low to below average range (DAS Word Definitions SS = 91, WDRB Oral Vocabulary SS = 83). Michael struggled to provide the complex responses needed to define words. In addition, his lack of reading

may also be impacting vocabulary development. His listening comprehension, or the ability to understand and respond to orally presented contextual material, is below average (WDRB, Listening Comprehension SS = 82). It appears that the more verbal material Michael is required to process, the poorer his performance. In comparing crystallized and fluid intelligence scores, it appears that Michael is ahead of many of his peers in novel reasoning tasks but is performing less well than many of them in storing and using learned information.

Cross-Battery Assessment of Gv. Visual Processing (Gv) is defined as the ability to analyze and synthesize visual stimuli and involves perceptions and manipulations of visual shapes and forms, typically when figural or geometric in nature. Michael's Visual Processing skills are within the average range (SS = 98). More specifically, his ability to perceive and mentally manipulate visual patterns (SS=96) and his visual memory (SS = 100) are within the average range.

Cross-Battery Assessment of Gsm. Short-term memory (Gsm) is the ability to hold information in immediate awareness and then use it within a few seconds. Michael' Gsm ability was assessed through tasks that required him to immediately recall digits and numbers in a given order, to recall nonsense words and to redraw geometric designs. Michael' overall short-term memory is at the low end of the average range (SS = 93). Michael does somewhat better with visual short-term memory (SS = 93) than with verbal (SS = 86). On the Phonological Memory composite of the CTOPP Michael received a standard score of 88. Michael' memory span for non-contextual material is at the low end of the average range (SS = 88).

Cross-Battery Assessment of Glr. Long-term storage and retrieval (Glr) is the ability to store information and fluently retrieve it later through association. Michael' overall long-term storage and retrieval skills are below average (SS = 86). However, it is important to consider his performance across subtests that measure the various aspects of long-term storage and retrieval. In tasks assessing Michael ability to learn over trials, he scored below average with verbal material (SS = 85), at the low end of the average range when associating verbal and visual stimuli (SS = 90) and well above average when working with visual material (SS = 130). When recalling meaningful material Michael performed at the low end of the average range with short sentences (SS = 90) but well below average when recalling stories (SS = 65). During speech and language testing, 11/99, auditory memory difficulties were also noted, particularly when the memory load increased. Ms. X significant concern about Michael inability to retain learned material is further indication of long-term memory and retrieval problems.

Naming facility is considered a component of long-term retrieval. The subtests used to assess naming facility required Michael to rapidly access verbal labels for numbers and letters. Michael' naming speed is below average (SS = 79). Difficulties with retrieving words and labels are often associated with impaired reading ability.

Cross-Battery Assessment of Ga. Auditory Processing (Ga) is the ability to analyze and synthesize auditory stimuli. The Comprehensive Test of Phonological Processing (CTOPP) was used to assess Michael' auditory processing. In addition, assessments from Lindamood-Bell, Ms. and Ms. were also considered. Michael is able to distinguish between similar sounding words (TAPS SS = 105, 11/99) and to discriminate words in noise, in degraded conditions and when presented with other words (SCAN, 5/00).

Michael' phonological processing ability was assessed through tasks that required him to integrate verbally presented syllables and/or phonemes (Blending Words SS = 100, Elision SS = 80). These tasks primarily measured Michael's ability to analyze the individual sounds in words (Phonetic Coding: Analysis) and synthesize such sounds (Phonetic Coding: Synthesis). Michael performed within the average range on simple phonological processing tasks (see also IEP from 2/00). However, on tasks requiring more complex manipulation of sounds, Michael is below average. More complex phonological processing tasks such as these require the use of graphemic markers such as numbers or letters for the sounds and are enhanced by

learning to read. Michael lacks facility in using these markers to support memory tasks (Michael also did poorly on the Lindamood Auditory Conceptualization Test) . The ability to manipulate the sounds of language is critical to the development of reading skill. That Michael continues to struggle with these tasks despite considerable intervention indicates his deficits in this area. It is important to note that Michael' deficits are in those tasks that students become more proficient at as they learn sound/symbol connections. His ability to accurately perceive the sounds of language, when presented in word form, appears to be intact.

Cross-Battery Assessment of Gs and Gt. Processing Speed (Gs) is defined as one's ability to quickly perform automatic cognitive tasks. On simple speed tasks requiring focused concentration, Michael performs within the average to above average range. Decision Time (Gt) is the ability to quickly make simple decisions. Michael works slowly on such tasks when mental comparison that uses verbal labels is required (Speed of Information Processing SS = 81). In addition, verbal material impacted his speed on repetitive attention tasks. When working with visual stimuli, Michael performed above average (SS = 120), whereas with verbal input, he performed at an average level. It is likely that auditory memory and naming speed deficits cause him to work slowly on verbally mediated tasks.

Attention/Executive Function: Attention deficits have previously been a significant problem for Michael and he is currently on medication for ADHD. Therefore, the Attention/Executive Function domain of the NEPSY was administered to Michael to assess his ability to engage in focused, sustained activity. Michael received a domain SS of 113, placing him above average. Michael performed at the average level or above on all three of the subtests. He enjoyed the activities and minimal errors. Michael' teacher, Ms. Hunt, reports that he attends appropriately in the classroom as well. Ms. notes that Michael is much more able to attend than in previous years.

Sensorimotor Functioning:
On the NEPSY Sensorimotor Domain Michael performed within the average range (SS = 98). His performance was in the average range on the three subtests comprising this domain.

SAMPLE CROSS-BATTERY REPORT 3

Cognitive Functioning:

The Differential Ability Scales (DAS) was given to Tanya as a general measure of a variety of different cognitive processes. The DAS is a standardized test designed to provide information on general conceptual skills as well as on specific cognitive abilities. Tanya completed the 6 core subtests which are grouped together to form composite scores as well as yield a General Conceptual Ability Score (GCA). The GCA score should be considered a composite of the three separate domains of cognitive functioning that are measured by the Cluster Scores. In addition to the GCA and Composite Scores, Tanya's performance on the individual subtests is useful in evaluating specific cognitive skills.

Subtests of The Wide Range Assessment of Memory and Learning (WRAML) were also administered. This test provided information on Tanya's verbal and visual memory as well as on her ability to link verbal and visual information as a measure of associative memory.

The Comprehensive Test of Phonological Processing (CTOPP) was administered in order to provide more information regarding cognitive processes commonly associated with reading disabilities.

Portions of the NEPSY, a developmental neuropsychological assessment were administered to assess attention, executive functioning, sensorimotor development, and associative memory.

The individual scores for these tests are presented at the end of this report. Like any such tests purporting to measure cognitive or intellectual abilities, it is important to remember that these scores represent a sample of Tanya's behavior.

Tanya's General Conceptual Ability score of 98, computed from her performance on the DAS, places her in the average range (45^{th} percentile) compared to other children her age. Her Nonverbal Reasoning and Spatial Cluster Scores are also in the average range and fall at the 63^{rd} and 50^{th} percentiles, respectively. Her Verbal Reasoning Cluster Score of 92 is also within the average range and falls at the 30^{th} percentile.

The results of cognitive testing were considered together via cross-battery principles and procedures to yield seven broad cognitive ability clusters including: fluid reasoning (Gf), crystallized intelligence (Gc) visual processing (Gv), short term memory (Gsm), long term retrieval (Glr) auditory processing (Ga) and processing speed (Gs).

Cross-Battery Assessment of Fluid Reasoning (Gf). Fluid reasoning can be described as the ability to reason, form concepts, and solve problems using unfamiliar information or novel procedures. The subtests used to measure Gf assessed Tanya's ability to detect patterns in both figural and numerical material. Tanya displays average fluid reasoning ability (broad ability SS = 106). On subtests assessing induction, seqeuntial reasoning and quantitative reasoning she received average range composites.

Cross-Battery Assessment of Gc. Crystallized Intelligence (Gc) is a broad ability that involves an individual's breadth and depth of general and cultural knowledge, verbal communication, and reasoning with previously learned procedures. The subtests that are seen to measure Gc assessed Tanya's knowledge of word meaning, verbal reasoning and verbal knowledge. Tanya received a Broad Ability rating in the average range (SS = 100). Her language development, as measured by her ability to form verbal categories is within the average range (DAS, Similarities SS = 100). Her listening comprehension, or the ability to understand and respond to orally presented contextual material, is high average (WDRB, Listening Comprehension SS = 112). However, her lexical knowledge, as assessed by her ability to define words and to provide synonyms and antonyms to orally presented words, is in the low to below average range (DAS Word Definitions SS = 83, WDRB Oral Vocabulary SS = 91). Formulating more complex responses

appears more difficult for Tanya than responding to context based questions. It may also be that her lack of reading has impacted vocabulary development.

Cross-Battery Assessment of Gv. Visual Processing (Gv) is defined as the ability to analyze and synthesize visual stimuli and involves perceptions and manipulations of visual shapes and forms, typically when figural or geometric in nature. Tanya's Visual Processing skills are within the average range (SS = 101). Her ability to perceive and mentally manipulate visual patterns is strong (DAS, Pattern Construction SS = 111). Her memory for visually presented material is at the low end of the average range (SS = 91).

Cross-Battery Assessment of Gsm. Short-term memory (Gsm) is the ability to hold information in immediate awareness and then use it within a few seconds. Tanya's Gsm ability was assessed through tasks that required her to immediately recall digits and numbers in a given order, to recall nonsense words and to redraw geometric designs. Tanya's overall short-term memory is at the low end of the average range (SS = 91). Her memory for verbal and visual material was similar. Subtest scores on verbal memory measures were somewhat lower for material that was non-meaningful ((WRAML Number/Letter SS = 88). This task is an indicator of immediate memory span, or how well one is able to hold and quickly recall non-meaningful material (such as when remembering a telephone number or what page to turn to in class).

Cross-Battery Assessment of Glr. Long-term storage and retrieval (Glr) is the ability to store information and fluently retrieve it later through association. Tanya's overall long-term storage and retrieval skills fall within the average range (SS = 104). However, her performance across subtests that measure various aspects of long-term storage and retrieval showed considerable variation. Her memory for meaningful material was within the average range (Story Memory SS = 100 , Sentence Memory SS = 95). In addition, on tests of associative memory she performed within the average range overall; however, her ability to learn associations between unfamiliar auditory and visual stimuli and to recall the verbal label when the visual stimuli was presented (WRAML, Sound-Symbol Learning = 78) was below average. In sum, Tanya did better with recall of meaningful material, or material that could be placed within a context, than with non-meaningful material.

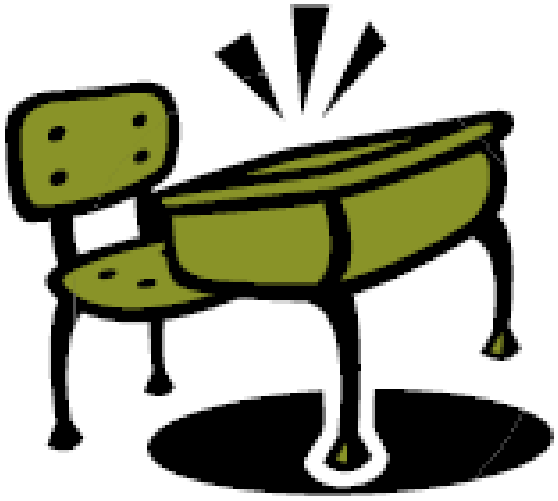
Naming facility is considered a component of long-term retrieval. The subtests used to assess naming facility required Tanya to rapidly access verbal labels for numbers and letters. Tanya's naming speed is at the low end of the average range. Her ability to rapidly access words based on beginning sound is limited, while her ability to rapidly access words based on category is at the low end of the average range. Ms. Taub, Speech and Language Specialist, also noted that Tanya worked very slowly on language related tasks and would likely have received a lower score had the tests been timed. Difficulties with retrieving words and labels are often associated with impaired reading ability.

Cross-Battery Assessment of Ga. Auditory Processing (Ga) is the ability to analyze and synthesize auditory stimuli. The Comprehensive Test of Phonological Processing (CTOPP) subtests were used to assess Tanya's auditory processing. In addition, language assessment data from 2/29/00 was also considered. Tanya's auditory processing ability was assessed through tasks that required her to integrate verbally presented syllables and/or phonemes into real and nonsense words (Blending Words SS = 100, Blending Nonwords SS = 100) and to segment real and nonsense words into their constituent sounds (Segmenting Words SS = 100, Segmenting Nonwords SS = 100). These tasks primarily measured Tanya's ability to analyze the individual sounds in words (Phonetic Coding: Analysis) and synthesize such sounds (Phonetic Coding: Synthesis). With more complex tasks, that required Tanya to store and manipulate sounds, her performance fell considerably (Elision SS = 70, Digits Backward SS = 80). In such tasks, successful performance requires the use of graphemic markers such as numbers or letters for the sounds. Tanya lacks facility in using these markers to support memory tasks. The ability to manipulate the sounds

of language is critical to the development of reading skill. That Tanya continues to struggle with these tasks despite considerable intervention indicates her deficits in this area.

Cross-Battery Assessment of Gs and Gt. Processing Speed (Gs) is defined as one's ability to quickly perform automatic cognitive tasks. On simple speed tasks requiring focused concentration, Tanya performs within the average range. Decision Time (Gt) is the ability to quickly make simple decisions. Tanya works slowly on such tasks when mental comparison is required (Speed of Information Processing SS = 79). Her processing speed is slowed when translating a visual symbol into a verbal label is required.

Attentional Processes. The Attention/Executive Function domain of the NEPSY was administered to assess attentional processes. In addition, portions of the BASC target behaviors indicative of ADHD. Tanya performs within the average range on tasks that require sustained attention and inhibiting of inappropriate responses (Attention/Executive Function Domain SS = 107). Neither her teacher nor her mother report behaviors indicative of ADHD.



Title 5. Education
Division 1. California Department of Education
Chapter 3. Individuals with Exceptional Needs
Subchapter 1. Special Education
Article 3.1. Individuals with Exceptional Needs

5 CCR § 3030

§ 3030. Eligibility Criteria.

(a) A child shall qualify as an individual with exceptional needs, pursuant to Education Code section 56026, if the results of the assessment as required by Education Code section 56320 demonstrate that the degree of the child's impairment as described in subdivisions (b)(1) through (b)(13) requires special education in one or more of the program options authorized by Education Code section 56361. The decision as to whether or not the assessment results demonstrate that the degree of the child's impairment requires special education shall be made by the IEP team, including personnel in accordance with Education Code section 56341(b). The IEP team shall take into account all the relevant material which is available on the child. No single score or product of scores shall be used as the sole criterion for the decision of the IEP team as to the child's eligibility for special education.

(b) The disability terms used in defining an individual with exceptional needs are as follows:

(1) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, and adversely affecting a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.
(A) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in subdivision (b)(4) of this section.
(B) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in subdivision (b)(1) of this section are satisfied.

(2) Deaf-blindness means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

(3) Deafness means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification that adversely affects a child's educational performance.

(4) Emotional disturbance means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(C) Inappropriate types of behavior or feelings under normal circumstances.
(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.
(F) Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under subdivision (b)(4) of this section.

(5) Hearing impairment means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but that is not included under the definition of deafness in this section.

(6) Intellectual disability means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance.

(7) Multiple disabilities means concomitant impairments, such as intellectual disability-blindness or intellectual disability-orthopedic impairment, the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. “Multiple disabilities” does not include deaf-blindness.

(8) Orthopedic impairment means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

(9) Other health impairment means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment that:
(A) Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and
(B) Adversely affects a child's educational performance.

(10) Specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may have manifested itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The basic psychological processes include attention, visual processing, auditory processing, sensory-motor skills, cognitive abilities including association, conceptualization and expression.
(A) Specific learning disabilities do not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of intellectual disability, of emotional disturbance, or of environmental, cultural, or economic disadvantage.
(B) In determining whether a pupil has a specific learning disability, the public agency may consider whether a pupil has a severe discrepancy between intellectual ability and achievement in oral expression, listening comprehension, written expression, basic reading skill, reading comprehension, mathematical calculation, or mathematical reasoning. The decision as to whether or not a severe discrepancy exists shall take into account all relevant material which is available on the pupil. No single score or product of scores, test or procedure shall be used as the sole criterion for the decisions of the IEP team as to the pupil's eligibility for special education. In determining the existence of a severe discrepancy, the IEP team shall use the following procedures:
1. When standardized tests are considered to be valid for a specific pupil, a severe discrepancy is demonstrated by: first, converting into common standard scores, using a mean of 100 and standard deviation of 15, the achievement test score and the intellectual ability test score to be compared; second, computing the difference between these common standard scores; and third, comparing this computed difference to the standard criterion which is the product of 1.5 multiplied by the standard deviation of the distribution of computed differences of students taking these achievement and ability tests. A computed difference which equals or exceeds this standard criterion, adjusted by one standard error of measurement,

the adjustment not to exceed 4 common standard score points, indicates a severe discrepancy when such discrepancy is corroborated by other assessment data which may include other tests, scales, instruments, observations and work samples, as appropriate.
2. When standardized tests are considered to be invalid for a specific pupil, the discrepancy shall be measured by alternative means as specified on the assessment plan.
3. If the standardized tests do not reveal a severe discrepancy as defined in subdivisions 1. or 2. above, the IEP team may find that a severe discrepancy does exist, provided that the team documents in a written report that the severe discrepancy between ability and achievement exists as a result of a disorder in one or more of the basic psychological processes. The report shall include a statement of the area, the degree, and the basis and method used in determining the discrepancy. The report shall contain information considered by the team which shall include, but not be limited to:
(i) Data obtained from standardized assessment instruments;
(ii) Information provided by the parent;
(iii) Information provided by the pupil's present teacher;
(iv) Evidence of the pupil's performance in the regular and/or special education classroom obtained from observations, work samples, and group test scores;
(v) Consideration of the pupil's age, particularly for young children; and
(vi) Any additional relevant information.
4. A severe discrepancy shall not be primarily the result of limited school experience or poor school attendance.
(C) Whether or not a pupil exhibits a severe discrepancy as described in subdivision (b)(10)(B) above, a pupil may be determined to have a specific learning disability if:
1. The pupil does not achieve adequately for the pupil's age or to meet State-approved grade-level standards in one or more of the following areas, when provided with learning experiences and instruction appropriate for the pupil's age or State-approved grade-level standards:
(i) Oral expression.
(ii) Listening comprehension.
(iii) Written expression.
(iv) Basic reading skill.
(v) Reading fluency skills.
(vi) Reading comprehension.
(vii) Mathematics calculation.
(viii) Mathematics problem solving, and
2.(i) The pupil does not make sufficient progress to meet age or State-approved grade-level standards in one or more of the areas identified in subdivision (b)(10)(C)(1) of this section when using a process based on the pupil's response to scientific, research-based intervention; or
(ii) The pupil exhibits a pattern of strengths and weaknesses in performance, achievement, or both, relative to age, State-approved grade-level standards, or intellectual development, that is determined by the group to be relevant to the identification of a specific learning disability, using appropriate assessments, consistent with 34 C.F.R. sections 300.304 and 300.305; and
3. The findings under subdivisions (b)(10)(C)(1) and (2) of this section are not primarily the result of:
(i) A visual, hearing, or motor disability;
(ii) Intellectual disability;
(iii) Emotional disturbance;
(iv) Cultural factors;
(v) Environmental or economic disadvantage; or
(vi) Limited English proficiency.
4. To ensure that underachievement in a pupil suspected of having a specific learning disability is not due to lack of appropriate instruction in reading or math, the group making the decision must consider:
(i) Data that demonstrate that prior to, or as a part of, the referral process, the pupil was provided appropriate instruction in regular education settings, delivered by qualified personnel; and

(ii) Data-based documentation of repeated assessments of achievement at reasonable intervals, reflecting formal assessment of student progress during instruction, which was provided to the pupil's parents.
5. In determining whether a pupil has a specific learning disability, the public agency must ensure that the pupil is observed in the pupil's learning environment in accordance with 34 C.F.R. section 300.310. In the case of a child of less than school age or out of school, a qualified professional must observe the child in an environment appropriate for a child of that age. The eligibility determination must be documented in accordance with 34 C.F.R. section 300.311.

(11) A pupil has a language or speech disorder as defined in Education Code section 56333, and it is determined that the pupil's disorder meets one or more of the following criteria:
(A) Articulation disorder.
1. The pupil displays reduced intelligibility or an inability to use the speech mechanism which significantly interferes with communication and attracts adverse attention. Significant interference in communication occurs when the pupil's production of single or multiple speech sounds on a developmental scale of articulation competency is below that expected for his or her chronological age or developmental level, and which adversely affects educational performance.
2. A pupil does not meet the criteria for an articulation disorder if the sole assessed disability is an abnormal swallowing pattern.
(B) Abnormal Voice. A pupil has an abnormal voice which is characterized by persistent, defective voice quality, pitch, or loudness.
(C) Fluency Disorders. A pupil has a fluency disorder when the flow of verbal expression including rate and rhythm adversely affects communication between the pupil and listener.
(D) Language Disorder. The pupil has an expressive or receptive language disorder when he or she meets one of the following criteria:
1. The pupil scores at least 1.5 standard deviations below the mean, or below the 7th percentile, for his or her chronological age or developmental level on two or more standardized tests in one or more of the following areas of language development: morphology, syntax, semantics, or pragmatics. When standardized tests are considered to be invalid for the specific pupil, the expected language performance level shall be determined by alternative means as specified on the assessment plan, or
2. The pupil scores at least 1.5 standard deviations below the mean or the score is below the 7th percentile for his or her chronological age or developmental level on one or more standardized tests in one of the areas listed in subdivision (A) and displays inappropriate or inadequate usage of expressive or receptive language as measured by a representative spontaneous or elicited language sample of a minimum of 50 utterances. The language sample must be recorded or transcribed and analyzed, and the results included in the assessment report. If the pupil is unable to produce this sample, the language, speech, and hearing specialist shall document why a fifty utterance sample was not obtainable and the contexts in which attempts were made to elicit the sample. When standardized tests are considered to be invalid for the specific pupil, the expected language performance level shall be determined by alternative means as specified in the assessment plan.

(12) Traumatic brain injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech.
(A) Traumatic brain injury does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.

(13) Visual impairment including blindness means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

Note: Authority cited: Section 56100, Education Code. Reference: Sections 56026, 56320, 56333 and 56337, Education Code; 20 U.S.C. Sections 1401(3)(A) and 1414(a) and (b); and 34 C.F.R. Sections 300.8, 300.300, 300.301, 300.304, 300.305, 300.306, 300.307, 300.308, 300.309 and 300.311.

Sample Report Eligibility Statements

Template conventions:
a) Text in **bold** specifies text to be adapted to personalize the statement for a given student.
b) Text in *italics* provides direction to the report author and should not be used within the report.

1. Autism
From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(1)]. **Name** is suggested to meet "autism" eligibility criteria as **he/she** exhibits significant verbal and nonverbal communication, and social interaction deficits. These challenges were evident early in **Name**'s development and are judged to significantly adversely affect **his/her** educational performance. These difficulties do not appear to be primarily due to an emotional disturbance [as defined in CCR, Title 5 §3030(b)(4)]. Other characteristics associated with "autism" and displayed by **Name** include: **engagement in repetitive activities and stereotyped movements**, **resistance to environmental change or change in daily routines**, and **unusual responses to sensory experiences**. *[NOTE: these associated characteristics are listed in §3030(b)(1), but are not specified as being required for eligibility as a student with autism.]*

2. Deaf/Blindness
From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(2)]. **Name** is suggested to meet "deaf/blind" eligibility criteria as **he/she** has concomitant hearing and visual impairments, the combination of which causes severe communication, developmental, and educational problems. It is suggested that **Name**'s vision and hearing challenges cannot be accommodated in special education programs solely for students with deafness or students with blindness.

3. Deaf
From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(3)]. **Name** is suggested to meet "deaf" eligibility criteria **he/she** has a hearing impairment that is so severe that **he/she** is impaired in processing linguistic information through hearing, with or without amplification. This impairment is suggested to adversely affect **Name**'s educational performance.

4. Emotionally Disturbed
Name appears to meet appears to meet eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(4)]. **Name** is suggested to meet "emotionally disturbed" eligibility criteria as from this assessment it has been suggested that **he/she** has an emotional condition, *[NOTE: as indicated specified the emotional condition* **here**,*]* that results in the following characteristic**(s)**: *[NOTE: only one of the following is required, but if a student displays more than one list all that apply]*
(A) An inability to learn which cannot be explained by intellectual, sensory, or health factors.
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(C) Inappropriate types of behavior or feelings under normal circumstances.
(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

This/These challenges appear to have existed for a long period of time, to a marked degree, and are suggested to adversely affect **Name**'s educational performance. **This/These** challenges do not appear to be solely due to social maladjustment.

5. Hearing impairment

From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(5)]. **Name** is suggested to meet "hearing impairment" eligibility criteria as **he/she** has a **permanent/fluctuating** hearing impairment, that adversely affects **Name**'s educational performance and is not included under the definition of deafness [as defined in CCR, Title 5, §3030(b)(3)].

6. Intellectual Disability

Name appears to meet eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(6)]. **Name** is suggested to meet "intellectual disability" eligibility criteria as **he/she** appears to have significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior. These challenges were manifested during the developmental period (which is generally thought to be birth to age 18 years) and are suggested to adversely affect **his/her** educational performance.

7. Multiple Disabilities

Name appears to meet appears to meet eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(7)]. **Name** is suggested to meet "multiple disabilities" eligibility criteria as **he/she** has the following concomitant impairments *[NOTE: must specify at least two of the following, with intellectual disability-blindness and intellectual disability-orthopedic impairment being two examples specifically mentioned in* §3030(b)(7)*]*: **autism, intellectual disability, blindness, deafness, orthopedic impairment, traumatic brain injury**. The combination of these disabilities is suggested to cause severe educational needs that cannot be accommodated in a special education program solely for one of the impairments. **Name** does not appear to meet criteria for dear-blindness (as defined in CCR, Title 5).

8. Orthopedic Impairment

From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(8)]. **He/She** has a severe orthopedic impairment, *[NOTE: specify the impairment* **here.** *These impairments may be disabilities caused by a congenital anomaly, disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and factors or burns that cause contractures]*, that adversely affects **Name**'s educational performance.

9. Other Health Impairment

From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(9)]. Name appears to meet "other health impairment" eligibility criteria as **he/she** is suggested to have **limited strength/vitality/alertness, heightened alertness to environmental stimuli with respect to the educational environment**, due to a **chronic**/**acute** health problem: *[NOTE: specify the impairment* **here** *Specific health problems offered in (b)(9) are "asthma, attention deficit disorder or attention deficit*

hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome.]. This health impairment is suggested to adversely affects **Name**'s educational performance.

10. Specific Learning Disability

Name appears to meet appears to meet eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(10)]. **Name** is suggested to meet "specific learning disability" criteria as **he/she** appears to have a disorder in the following basic psychological process**(es)** involved in understanding or in using **spoken/written** language: *[List the basic psychological processing disorder(s)* **here***. NOTE: Examples of basic psychological processes mentioned in (b)(10) are: "attention, visual processing, auditory processing, sensory-motor skills, cognitive abilities including association, conceptualization and expression." Specific "conditions" that can result in these processing disorders, offered as examples of a "specific learning disability", and mentioned in (b)(10) are "perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia."]*. For **Name,** this specific learning disability appears to result in an imperfect ability to **listen, think, speak, read, write, spell, do mathematical calculations**. **Name**'s learning problems are not primarily the result of visual, hearing, or motor difficulties; of intellectual disability; of emotional disturbance; or of environmental, cultural, or economic disadvantage. Nor can they be primarily attributed to limited school experience or poor school attendance. Further data is available that demonstrates **he/she** was provided appropriate general education instruction by qualified professionals and that prior to this referral there was data-based documentation of repeated assessments of achievement at reasonable intervals, which reflecte formal assessment of **Name**'s progress during instruction (data that was provided to **his/her** parents).

[Use the following in school districts that make use of a response to intervention (or RTI) model.] Evidence that the basic psychological processing deficit has adversely affected **Name**'s educational performance includes that **he/she** does not achieve adequately for **his/her** age to meet State-approved grade level standard in the following area**(s)** even after having been provided with appropriate learning experiences and instruction: *[Specify the area(s)* **here** *from the list of the following]* **oral expression, listening comprehension, written expression, basic reading skill, reading fluency skill, reading comprehension, mathematics calculation, mathematics problem solving**. Further, **Name** is suggested to have not made sufficient progress to meet age or State-approved grade-level standards in these areas despite the use of scientific, research-based interventions.

[Use the following in school districts that make use of a response to processing strengths and weaknesses model.] Evidence that the basic psychological processing deficit has adversely affected **Name**'s educational performance includes that **he/she** does not achieve adequately for **his/her** age to meet State-approved grade level standard in the following area**(s)** even after having been provided with appropriate learning experiences and instruction: *[Specify the area(s)* **here** *from the list of the following]* **oral expression, listening comprehension, written expression, basic reading skill, reading fluency skill, reading comprehension, mathematics calculation, mathematics problem solving**. Further, **Name** appears to exhibit a pattern of strengths and weaknesses in **performance**/**achievement**/**performance and achievement** relative to **his/her age/State-approved grade-level standards/intellectual development**.

[Use the following in school districts that still make use of the now outdated and widely discredited discrepancy model.] In the **SchoolDistrictName** School District eligibility for special education, as a student with a specific learning disability, also requires a severe discrepancy between intellectual ability and achievement (as specified in **§** 3030(10)(B)(**1)/(2)/(3**). *[NOTE: List "(1)" when the tests used to obtain the discrepancy are judged to be valid. List "(2)" when the tests used to obtain the discrepancy are judged to be invalid and then specify the alternative procedures used to determine the "discrepancy." List "(3)" if the IEP team finds a severe discrepancy to exist despite the obtained test scores. When using this last criterion the report must include a statement of the area, the degree, and the basis and method used in determining the discrepancy, and the report must include data obtained from the standardized assessment*

instruments; information provided by the parent and the students teacher, evidence of the student's performance in the general and/or special education classroom obtained from observations, work samples, and group test scores; consideration of the student's age, especially for young children, and any additional relevant information.] From the assessment data it is suggested that there is an educationally significant discrepancy between **Name**'s intellectual ability and achievement test scores in the area**(s)** of *[Specify the area(s)* **here** *from the list of the following]* **oral expression/listening comprehension/written expression/basic reading skill/reading comprehension/mathematical calculation/mathematical reasoning**. Further, there is a logical connection between **this/these** low achievement test score**(s)** and the basic psychological processing disorder identified above. This discrepancy does not appear to be primarily the result of limited school experiences or poor school attendance. The ability/achievement discrepancy would not appear to be due to poor school attendance. It should also be noted that in the opinion of the Examiner, this learning problem could not be corrected within the general education program.

11. Language or Speech Disorder

From assessment conducted by the speech and language specialist it has been suggested that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(11)]. **Name** appears to meet "language or speech disorder" eligibility criteria as **he/she** has been suggested to have *[From consultation with the speech and language specialist specify the disorder* **here** *from the list of the following]* **an articulation disorder, abnormal voice, a fluency disorder, a language disorder**.

12. Traumatic Brain Injury

From assessment conducted by the speech and language specialist it has been suggested that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(12)]. **Name** appears to meet "traumatic brain injury" eligibility criteria as **he/she** has an acquired injury to the brain that is the result of an external physical force. As the result of this injury **Name** has **total/partial functional disability/psychosocial impairment** that is suggested to adversely affects **his/her** educational performance. From the assessment data it appears that **Name**'s **close/open** head injury has resulted in impairment**(s)** in the following area**(s)**: *[Specify the area(s)* **here.** *The following list provides examples]* **cognition; language; memory; attention; reasoning; abstract thinking; judgement; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; speech.** This is not a congenital or degenerative injury and was not induced by birth trauma.

Vision Impairment

From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs [according to the California Code of Regulations - Title 5; Division 1; Chapter 3, Individuals with Exceptional Needs; Subchapter 1, Special Education; Article 3.1, Individuals with Exceptional Needs; §3030(b)(13)]. **Name** is suggested to meet "vision impairment" eligibility criteria as **he/she** has a visual impairment (**partial sight**/**blindness**) that, even with correction, can be argued to adversely affects **his/her** educational performance.

SAMPLE PSYCHO-EDUCATIONAL REPORT TEMPLATES

WOODCOCK-JOHNSON III TESTS OF COGNITIVE ABILITIES

To assess **NAME**'s cognitive functioning the *Woodcock Johnson III Tests of Cognitive Abilities* (WJIII-COG) was administered. The *WJIII-COG* can be used to provide information on overall intellectual functioning and to identify specific cognitive strengths and weaknesses. NAME's overall General Intellectual Ability (GIA) score was ## (90% CI, ###-###), which falls at the ##^{th,nd,st} percentile rank, and is in the **RANGE** range of standard scores. From these results the examiner is able to conclude that **NAME** has the overall cognitive ability to progress academically.

Cluster and corresponding subtest scores are reported below in three tables; (a) overall Performance Clusters, (b) narrowly focused Clinical Clusters, and (c) theoretically driven CHC Clusters. Analysis of these results reveals a pattern of learning strengths and weaknesses. Specifically, .

Performance Clusters					
Cluster Subtest	**Stimuli/ Response**	**Testing Requirements**	**Cognitive Processes**	**Standard Score** (90% CI)	**%ile** Interpretation
Verbal Ability			**Language development, and comprehension of words & relationships among words**	**###** ()	**##** RANGE
Verbal Comprehension	Visual (pictures); Auditory (words)/ Oral (words)	Identifying objects; knowledge of antonyms and synonyms; completing verbal analogies	Object recognition and re-identification; semantic activation, access, and matching; verbal analogical reasoning	### ()	## RANGE
General Information	Auditory (questions)/ Oral (sentences)	Identifying where objects are found and what people typically do with an object	Semantic activation and access to declarative generic knowledge	### ()	## RANGE
Thinking Ability			**Thinking used when information in short term memory can't be automatically processed**	**97** (94-100)	**42** Average
Visual Auditory Learning	Visual (rebuses)-Auditory (words) during learning; Visual (rebuses) during recognition/ Oral (sentences)	Learning and recalling pictographic representations of words	Paired-associative encoding via directed spotlight attention; storage and retrieval	### ()	## RANGE
Spatial Relations	Visual (drawings)/ Oral (letters) or motoric (pointing)	Identifying the subset of pieces needed to forma a complete shape	Visual feature detection; manipulation of visual images in space; matching	### ()	## RANGE
Sound Blending	Auditory (phonemes)/ Oral (words)	Synthesizing language sounds (phonemes)	Synthesis of acoustic, phonological elements in immediate awareness; matching the sequence of elements to stored lexical entries; lexical activation and access	### ()	## RANGE
Concept Formation	Visual (drawings)/ Oral (words)	Identifying, categorizing, and determining rules	Rule-based categorization; rule switching; induction/inference	### ()	## RANGE

Retrieval Fluency	Auditory (directions)/ Oral (words)	Naming as many examples as possible from a given category	Recognition, fluent retrieval, and oral production of examples of a semantic category	### ()	## RANGE
Picture Recognition	Visual (pictures)/ Oral (words) or motoric (pointing)	Identifying a subset of previously presented pictures within a field of distracting pictures	Formation of iconic memories and matching of visual stimuli to stored representations	### ()	## RANGE
Auditory Attention	Auditory (words)/ Motoric (pointing)	Identifying auditorily presented words amid increasingly intense background noise	Selective auditory attention	### ()	## RANGE
Analysis Synthesis	Visual (drawings)/ Oral (words)	Analyzing puzzles (using symbolic formulations) to determine missing components	Algorithmic reasoning; deduction	### ()	## RANGE
Cognitive Efficiency			**Ability to process information automatically**	**### ()**	**## RANGE**
Visual Matching	Visual (numbers)/ Motoric (circling)	Rapidly locating and circling identical numbers from a defined set of numbers	Speeded visual perception and matching	### ()	## RANGE
Numbers Reversed	Auditory (numbers)/ Oral (numbers)	Holding a span of numbers in immediate awareness while reversing the sequence	Span of apprehension and recoding in working memory	### ()	## RANGE
Decision Speed	Visual (pictures)/ Motoric (circling)	Locating and circling two pictures most similar conceptually in a row	Object recognition and speeded symbolic/ semantic comparisons	### ()	## RANGE
Memory for Words	Auditory (words)/ Oral (words)	Repeating a list of unrelated words in correct sequence	Formation of echoic memories and verbalizable span of echoic store	### ()	## RANGE

Clinical Clusters					
Cluster Subtest	**Stimuli/ Response**	**Testing Requirements**	**Cognitive Processes**	**Standard Score** (68% CI)	**%ile** Interpretation
Phonemic Awareness			**Analysis and synthesis of speech sounds**	**###** ()	**##** RANGE
Sound Blending	Auditory (phonemes)/ Oral (word)	Synthesizing language sounds (phonemes)	Synthesis of acoustic, phonological elements in immediate awareness; matching the sequence of elements to stored lexical entries; lexical activation and access	### ()	## RANGE
Incomplete Words	Auditory (words)/ Oral (word)	Identifying words with missing phonemes	Analysis of a sequence of acoustic, phonological elements in immediate awareness: activation of a stored representation of the word from an incomplete set of phonological features	### ()	## RANGE
Working Memory			**Holding information in immediate awareness while mentally manipulating the it**	**###** ()	**##** RANGE
Numbers Reversed	Auditory (numbers)/ Oral (numbers)	Holding a span of numbers in immediate awareness while reversing the sequence	Span of apprehension and recoding in working memory	### ()	## RANGE
Auditory Working Memory	Auditory (words, numbers)/ Oral (words, numbers)	Holding a mixed set of numbers and words in immediate awareness while reordering into two sequences	Recoding of acoustic, verbalizable stimuli held in immediate awareness	### ()	## RANGE
Broad Attention			**Focused, sustained, and divided attention**	**###** ()	**##** RANGE
Numbers Reversed	Auditory (numbers)/ Oral (numbers)	Holding a span of numbers in immediate awareness while reversing the sequence	Span of apprehension and recoding in working memory	### ()	## RANGE

Auditory Working Memory	Auditory (words, numbers)/ Oral (words, numbers)	Holding a mixed set of numbers and words in immediate awareness while reordering into two sequences	Recoding of acoustic, verbalizable stimuli held in immediate awareness	### ()	## RANGE
Auditory Attention	Auditory (words)/ Motoric (pointing)	Identifying auditorily presented words amid increasingly intense background noise	Selective auditory attention	### ()	## RANGE
Pair Cancellation	Visual (pictures)/ Motoric (circling)	Identifying and circling instances of a repeated pattern rapidly	Controlled, focal attention; vigilance	### ()	## RANGE
Cognitive Fluency			**Speed/ease of cognitive task performance**	**###** ()	**##** RANGE
Retrieval Fluency	Auditory (directions)/ Oral (words)	Naming as many examples as possible from a given category	Recognition, fluent retrieval, and oral production of examples of a semantic category	### ()	## RANGE
Decision Speed	Visual (pictures)/ Motoric (circling)	Locating and circling two pictures most similar conceptually in a row	Object recognition and speeded symbolic/ semantic comparisons	### ()	## RANGE
Rapid Picture Naming	Visual (pictures)/ Oral (words)	Recognizing objects, then articulating their names rapidly	Speed/fluency of retrieval and oral production of recognized objects	### ()	## RANGE
Executive Processes			**Strategic planning, proactive inference control, and ability to shift mental set**	**###** ()	**##** RANGE
Concept Formation	Visual (drawings)/ Oral (words)	Identifying, categorizing, and determining rules	Rule-based categorization; rule switching; induction/inference	### ()	## RANGE
Planning	Visual (drawing)/ Motoric (tracing)	Tracing a pattern without removing the pencil from the paper or retracing any lines	Means-end analysis	### ()	## RANGE
Pair Cancellation	Visual (pictures)/ Motoric (circling)	Identifying and circling instances of a repeated pattern rapidly	Controlled, focal attention; vigilance	### ()	## RANGE

CHC Clusters					
Cluster Subtest	**Stimuli/ Response**	**Testing Requirements**	**Cognitive Processes**	**Standard Score** (68% CI)	**%ile** Interpretation
Comprehension Knowledge (*Gc*)			**Breadth/depth of acquired knowledge, ability to communicate knowledge, & to reason using prior learning**	**###** ()	**##** RANGE
Verbal Comprehension	Visual (pictures); Auditory (words)/ Oral (words)	Identifying objects; knowledge of antonyms and synonyms; completing verbal analogies	Object recognition and re-identification; semantic activation, access, and matching; verbal analogical reasoning	### ()	## RANGE
General Information	Auditory (questions)/ Oral (sentences)	Identifying where objects are found and what people typically do with an object	Semantic activation and access to declarative generic knowledge	### ()	## RANGE
Long Term Retrieval (*Glr)*			**Store information and quickly remember it**	**###** ()	**##** RANGE
Visual Auditory Learning	Visual (rebuses)-auditory (words) during learning; Visual (rebuses) during recognition / Oral (sentences)	Learning and recalling pictographic representations of words	Paired-associative encoding via directed spotlight attention; storage and retrieval	### ()	## RANGE
Retrieval Fluency	Auditory (directions)/ Oral (words)	Naming as many examples as possible from a given category	Recognition, fluent retrieval, and oral production of examples of a semantic category	### ()	## RANGE
Visual-Spatial Thinking (*Gv)*			**Perceive, analyze, synthesize and think with visual patterns, includes the ability to store and recall**	**###** ()	**##** RANGE
Spatial Relations	Visual (drawings)/ Oral (letters) or motoric (pointing)	Identifying the subset of pieces needed to forma a complete shape	Visual feature detection; manipulation of visual images in space; matching	### ()	## RANGE
Picture Recognition	Visual (pictures)/	Identifying a subset of previously presented pictures	Formation of iconic memories and matching of visual stimuli to stored	### ()	## RANGE

	Oral (words) or motoric (pointing)	within a field of distracting pictures	representations		
Planning	Visual (drawing)/ Motoric (tracing)	Tracing a pattern without removing the pencil from the paper or retracing any lines	Means-end analysis	### ()	## RANGE
Auditory Processing (*Ga*)			**Analyze, synthesize, discriminate auditory stimuli, including the ability to process/discriminate speech sounds under distorted conditions**	**### ()**	**## RANGE**
Sound Blending	Auditory (phonemes)/ Oral (word)	Synthesizing language sounds (phonemes)	Synthesis of acoustic, phonological elements in immediate awareness; matching the sequence of elements to stored lexical entries; lexical activation and access	### ()	## RANGE
Incomplete Words	Auditory (words)/ Oral (word)	Identifying words with missing phonemes	Analysis of a sequence of acoustic, phonological elements in immediate awareness: activation of a stored representation of the word from an incomplete set of phonological features	### ()	## RANGE
Auditory Attention	Auditory (words)/ Motoric (pointing)	Identifying auditorily presented words amid increasingly intense background noise	Selective auditory attention	### ()	## RANGE
Fluid Reasoning (*Gf*)			**Reasoning, forming concepts, and solving problems using familiar or novel information/procedures**	**### ()**	**## RANGE**
Concept Formation	Visual (drawings)/ Oral (words)	Identifying, categorizing, and determining rules	Rule-based categorization; rule switching; induction/inference	### ()	## RANGE
Analysis Synthesis	Visual (drawings)/ Oral (words)	Analyzing puzzles (using symbolic formulations) to determine missing components	Algorithmic reasoning; deduction	### ()	## RANGE
Planning	Visual (drawing)/ Motoric (tracing)	Tracing a pattern without removing the pencil from the paper or retracing any lines	Means-end analysis	### ()	## RANGE

CHC Clusters (continued)					
Cluster Subtest	**Stimuli/ Response**	**Testing Requirements**	**Cognitive Processes**	**Standard Score** (68% CI)	**%ile** Interpretation
Processing Speed (*Gs*)			**Ability to perform simple/automatic cognitive tasks quickly**	**###** ()	**##** RANGE
Visual Matching	Visual (numbers)/ Motoric (circling)	Rapidly locating and circling identical numbers from a defined set of numbers	Speeded visual perception and matching	### ()	## RANGE
Decision Speed	Visual (pictures)/ Motoric (circling)	Locating and circling two pictures most similar conceptually in a row	Object recognition and speeded symbolic/ semantic comparisons	### ()	## RANGE
Rapid Picture Naming	Visual (pictures)/ Oral (words)	Recognizing objects, then articulating their names rapidly	Speed/fluency of retrieval and oral production of recognized objects	### ()	## RANGE
Pair Cancellation	Visual (pictures)/ Motoric (circling)	Identifying and circling instances of a repeated pattern rapidly	Controlled, focal attention; vigilance	### ()	## RANGE
Short-Term Memory (*Gsm*)			**Apprehend and hold information in immediate awareness and use it within a few seconds**	**###** ()	**##** RANGE
Numbers Reversed	Auditory (numbers)/ Oral (numbers)	Holding a span of numbers in immediate awareness while reversing the sequence	Span of apprehension and recoding in working memory	### ()	## RANGE
Auditory Working Memory	Auditory (words, numbers)/ Oral (words, numbers)	Holding a mixed set of numbers and words in immediate awareness while reordering into two sequences	Recoding of acoustic, verbalizable stimuli held in immediate awareness	### ()	## RANGE
Memory for Words	Auditory (words)/ Oral (words)	Repeating a list of unrelated words in correct sequence	Formation of echoic memories and verbalizable span of echoic store	68 (63-74)	2 Very Low

NAGLIERI NONVERBAL ABILITY TEST

To assess **NAME**'s reasoning skills, the *Naglieri Nonverbal Ability Test* (NNAT) was administered. The *NNAT* can be used to provide information on general reasoning skill. **NAME**'s obtained standard score on this measure was ### (90% CI, ### - ###; ##th/nd/st %ile rank), is in the **RANGE** range of scores.

WOODCOCK-JOHNSON III TESTS OF ACHIEVEMENT

The *Woodcock-Johnson III Tests of Achievement* (WJIII ACH) is a nationally standardized measure of academic achievement. **NAME**'s obtained test scores on this measure are as follows:

Cluster *Subtest*	*Standard Score*	*90% Confidence Interval*	*%ile Rank*
Broad Reading	###	###-###	##
Letter-Word Identification	###	###-###	##
Reading Fluency	###	###-###	##
Passage Comprehension	###	###-###	##
Broad Math	###	###-###	##
Calculation	###	###-###	##
Math Fluency	###	###-###	##
Applied Problems	###	###-###	##
Broad Written Language	###	###-###	##
Spelling	###	###-###	##
Writing Fluency	###	###-###	##
Writing Samples	###	###-###	##
Academic Skills	###	###-###	##
Academic Fluency	###	###-###	##
Academic Applications	###	###-###	##
Total Achievement	###	###-###	##

KAUFMAN TEST OF EDUCATIONAL ACHIEVEMENT

The *Kaufman Test of Educational Achievement* (2nd ed., KTEA-II) is a nationally standardized measure of academic achievement. Results are as follows:

Composite Subtests	Raw Score	Standard Score	90% Confidence Interval	%ile Rank
Reading	###	###	###-###	##
Letter & Word Recognition	##	###	###-###	##
Reading Comprehension	##	###	###-###	##
Nonsense Word Decoding	##	###	###-###	##
Math	###	###	###-###	##
Concepts & Applications	##	###	###-###	##
Computation	##	###	###-###	##
Written Language	###	###	###-###	##
Written Expression	##	###	###-###	##
Spelling	##	###	###-###	##

GRAY ORAL READING TEST

The *Gray Oral Reading Test* (Fifth Edition, GORT-5) is a measure of oral reading fluency and comprehension. On this measure Kyra obtained the following scores:

Subtest	Raw Scores	Scaled Score	%ile Rank	Age Equivalent	Grade Equivalent
Rate					
Accuracy					
Fluency					
Comprehension					
Oral Reading Quotient					

TEST OF WORD READING EFFICIENCY

The *Test of Word Reading Efficiency* (2nd Edition; TOWRE2; Form A) is a measure of an individual's ability to read out loud printed text accurately and quickly (reading fluency). On it **NAME** was asked to read as many printed words as possible in 45 seconds (Sight Word Efficiency), and as many pronounceable printed non-words (e.g., "mibgus") as possible in 45 seconds (Phonemic Decoding Efficiency). The following Table provides a summary of **NAME**'s *TOWRE* performance.

Subtest	*Raw Score*	*Percentile Rank*	*Standard Score*
Sight Word Efficiency			
Phonemic Decoding Efficiency			
Total Word Reading Efficiency			

TEST OF SILENT WORD READING EFFICIENCY

The *Test of Silent Word Reading Efficiency* (Form A; TOSWRE) is a measure of an individual's ability to recognize printed words accurately and quickly (reading fluency). On it **NAME** was presented with rows of words that had no spaces between them (e.g., dimhowfigblue). **S/He** was then given three minutes to draw lines between the boundaries of as many words as possible. On this test **NAME** obtained a raw score of ###, which when compared to the performance of same aged peers, fell at the ##th,nd,st percentile rank and corresponded to a standard score of ###, and age equivalent of ##-## (CA: ##-##), and a grade score of #.#. Such a result is described by the *TOSWRE's* manual as "**RANGE**."

TEST OF AUDITORY PROCESSING SKILLS

The *Test of Auditory Processing Skills* (3rd ed.; TAPS-3) is a measure of auditory skills important to the development, use, and understanding of the language used in academic instruction. It includes subtests designed to assess basic phonological skills (which are important to learning to read), memory abilities (essential to processing information), and auditory cohesion (which requires not only understanding, but also the ability to use inference, deduction and abstraction to comprehend the meaning of verbally presented information). On this measure **NAME** obtained an overall auditory processing standard score of ### (90% CI, ###-###; ##th,nd,st %ile rank), which falls within the **RANGE** range. Subtest and Index results are as follows:

Index *Subtest*	*Standard Scores*	*90% Confidence Interval*	*%ile Rank*
Phonological	**###**	**###-###**	**##**
Word Discrimination	###	###-###	##
Phonological Segmentation	###	###-###	##

Phonological Blending	###	###-###	##
Memory	**###**	**###-###**	**##**
Number Memory Forward	###	###-###	##
Number Memory Reversed	###	###-###	##
Word Memory	###	###-###	##
Sentence Memory	###	###-###	##
Cohesion	**###**	**###-###**	**##**
Auditory Comprehension	###	###-###	##
Auditory Reasoning	###	###-###	##

COMPREHENSIVE TEST OF PHONOLOGICAL PROCESSING

The *Comprehensive Test of Phonological Processing* (CTOPP) assesses phonological awareness, phonological memory, and rapid naming. Students with deficits in one or more of these abilities may have difficulty learning to read. The Phonological Awareness Quotient measures awareness of, and access to, the phonological (or sound) structure of oral language. The Phonological Memory Quotient measures the ability to hold phonological information (numbers and word parts) in working or short-term memory. The Rapid Naming Quotient measures the ability to quickly and efficiently retrieve phonological information from long-term memory. The following Table summarizes **NAME**'s *CTOPP* performance.

Subtest	*Raw Score*	*%ile Rank*	*Standard Score*	*Composite*	*%ile Rank*	*Standard Score*
Elision				Phonological Awareness		
Blending Words				Phonological Memory		
Memory for Digits				Rapid Naming		
Rapid Digit Naming						
Nonword Repetition						
Rapid Letter naming						

DEVELOPMENTAL TEST OF VISUAL-MOTOR INTEGRATION

The *Developmental Test of Visual-Motor Integration* (VMI) is a developmental sequence of geometric forms to be copied with pencil and paper. This test measured **NAME**'s ability to integrate a visual perception with a fine motor response (eye-hand coordination). On it **NAME** obtained a raw score of ##, which when compared to the performance of same aged peers, falls at the ##^{th,rd,st} percentile rank and corresponds to a standard score of **##**. This result is considered to be .

BEHAVIOR ASSESSMENT SYSTEM FOR CHILDREN, SECOND EDITION: SELF-REPORT OF PERSONALITY

To assess **NAME**'s social-emotional functioning **s/he** was asked to respond to the *Behavioral Assessment System for Children, Second Edition: Self-Report of Personality* (BASC-2 SRP). On this measure **NAME** responded to 175 statements about **his/her** behavior, emotions, thoughts and perceptions. Clinical Scales provide an estimate of **NAME**'s level of distress in a variety of areas, while Adaptive Scales focus on positive psychological adjustment.

Clinical Scales ***(Level of Distress)***	***Scale Definitions***	***T-Scores*** Scores 60 or higher are of concern
Attitude to School	The tendency to feel alienated, hostile, or dissatisfied toward school	

Attitude to Teachers	The tendency to resent or dislike teachers or think they are unfair	
Sensation Seeking	The tendency to take risks and seek excitement	
School Problems		
Atypicality	Excessive thoughts and behaviors that are often considered odd or unusual	
Locus of Control	The belief that rewards and punishments re controlled by external events or other people	
Social Stress	Feeling lonely, isolated, or "picked on" in social situations	
Anxiety	The tendency to be nervous, fearful, or worried about real or imagined problems	
Depression	Excessive feelings of unhappiness, sadness, or stress	
Sense of inadequacy	The tendency to feel unsuccessful or generally inadequate	
Somatization	The tendency to be overly sensitive or to complain about relatively minor physical problems/discomfort	
Internalizing Problems		
Attention Problems	The tendency to be easily distracted and unable to concentrate for an extended period of time	
Hyperactivity	The tendency to be overly active, rush through work or activities, and act without thinking	
Inattention/Hyperactivity		
Emotional Symptoms Index		
Adaptive Scales (Positive Psychological Adjustment)	***Scale Definitions***	***T-Scores*** Scores 40 or lower are of concern
Relations with Parents	The tendency to feel valued and supported by parents	
Interpersonal Relations	Feeling liked and respected by peers	
Self-Esteem	Feelings of self-respect and self-worth	
Self-Reliance	Thinking that one is dependable and being confident of one's abilities	
Personal Adjustment		

BEHAVIOR ASSESSMENT SYSTEM FOR CHILDREN, SECOND EDITION: PARENT AND TEACHER RATING SCALES

To assess **NAME**'s social-emotional functioning **his/her** caregivers were asked to respond to the *Behavioral Assessment System for Children, Second Edition: Parent* and *Teacher Rating Scales* (BASC-2 PRS; BASC-2 TRS). On this measure his mother, father, and teacher responded to statements about **NAME**'s behavior and feelings. Clinical Scales provides an estimate of **NAME**'s disruptive behaviors or internal problems, while Adaptive Scales focused on positive psychological features and skills. Results are as follows:

Clinical Scales (Disruptive behaviors/Internal Problems)	***Scale Definitions***	***Mother***	***Father***	***Teacher***
Hyperactivity				
Aggression				
Conduct Problems				
Externalizing Problems				
Anxiety				
Depression				
Somatization				
Internalizing Problems				
Atypicality				
Withdrawal				
Attention Problems				
Learning Problems				
School Problems				
Behavioral Symptoms Index				
Adaptive Scales (Positive Psychological Features/Skills)	***Scale Definitions***	***Mother***	***Father***	***Teacher***
Adaptability				
Social Skills				
Leadership				
Activities of Daily Living				
Functional Communication				
Study Skills				
Adaptive Skills				

CHILD/ADOLESCENT REPORT OF POSTTRAUMATIC SYMPTOMS

The *Child/Adolescent Report of Posttraumatic Symptoms* (CROPS) is a 26 item self-report screening questionnaire designed to measure a broad range of posttraumatic symptoms. On this measure **NAME** obtained a raw score of ## (score range = 0 to 52). Items endorsed by **NAME** as being especially true for her in the past week (i.e., rated "Lots") were:

-

As the cut-off score for clinical concern is 19, this result suggests

REYNOLDS CHILD DEPRESSION SCALE

The *Reynolds Child Depression Scale* (RCDS) is designed to screen for depression in children in grades 3 to 6). It provides a self reported measure of the severity of a child's depressive symptoms. On this measure **NAME** obtained a raw score of ## (score range = 30 to 121), which falls at the ##^{th,rd,st} percentile rank.

CONNERS 3

The *Conners 3* offers a thorough assessment of ADHD and frequently comorbid disorders such as Oppositional Defiant Disorder and Conduct Disorder. **NAME**'s **mother**/**father** was asked to respond to the Parent version of this scale. Results are summarized in the following table:

Scale	***Characteristics of High Scores***	***T-score (Percentile)***	***Score Guideline***
Inattention	May have poor concentration/attention or difficulty keeping his/her mind on work. May make careless mistakes. May be easily distracted. May give up easily or be easily bored. May avoid schoolwork.	## ()	
Hyperactivity/Impulsivity	High activity levels, may be restless and/or impulsive. May have difficulty being quiet. May interrupt others. May be easily excited.	## ()	
Learning Problems	Struggles with reading, spelling, and/or math. May have difficulty remembering concepts.	## ()	
Executive Functioning	May have difficulty starting or finishing projects, may complete projects at the last minute. May have poor planning, prioritizing, or organizational skills.	## ()	
Defiance/Aggression	Physically and/or verbally aggressive. May show violent or destructive tendencies. May bully others. May be argumentative. May have poor control of anger and/or aggression. May be manipulative or cruel. May have legal issues.	## ()	
Peer Relations	May have difficulty with friendships, poor social skills, limited social skills. May appear to be unaccepted by group.	## ()	
Global Index Total	**May be moody and emotional, or restless, impulsive or inattentive**	**## ()**	
DSM-IV-TR ADHD Inattentive		**## ()**	
DSM-IV-TR ADHD Hyperactive-Impulsive		**## ()**	
DSM-IV-TR Conduct Disorder		**## ()**	
DSM-IV-TR Oppositional Defiant Disorder		**## ()**	