CST Evaluation Planning Form

CST Team Members: _____ Date: _____

Student's Name: _____ Grade: _____ DOB: _____

Ethnicity: _____

Vision Concerns:	Hearing Concerns:	Attendance Issues:	Previous Evaluations:	Outside Evaluations:	Medical Diagnosis*:
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

*If yes (Medical Diagnosis) please describe here:	If a student has ADHD, is the diagnosis from a provider with the necessary credentials to consider OHD (Doctor, LP, APRN, Psychiatrist)?

Meds:	Yes ☐ No ☐	CTSS:	Yes ☐ No ☐

Behavior: If considering behavior, has it been occurring for a minimum of 6 months, or results from the well-documented, sudden onset of a serious mental health disorder diagnosed by a licensed mental health professional?	Yes ☐ No ☐

Areas of Concern (Check all that apply):

Reading Fluency	☐	Reading Comprehension	☐	Basic Reading Skills	☐	Written Expression	☐
Math Problem Solving	☐	Math Calculation	☐	Oral Expression	☐	Health	☐
Behavior	☐	Adaptive Functioning	☐	Social/Emotional	☐	Fine Motor	☐
		Speech/Language	☐	Sensory	☐	Gross Motor	☐

Two Interventions completed in area of concern?	Yes ☐ No ☐	Do we have enough data to move forward with an evaluation?	Yes ☐ No ☐

If "No" why was the referral rejected by the team?

Area to be evaluated (consult criteria if needed)

SLD ☐ OHD ☐ DCD ☐ EBD ☐ ASD ☐ DHH ☐ OHI ☐

DD ☐ Speech/Language ☐ OT ☐ VI ☐ DAPE ☐

Necessary Consultation Forms Completed?	Yes ☐ No ☐	Transition Needed?	Yes ☐ No ☐