



# PILGRIM AREA COLLABORATIVE

## Extended Services

*Deb Booth, M.Ed., PACES Director*

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*Connecting SCHOOL – HOME - COMMUNITY*

### Professional Evaluation Request

- 1 District Special Education office completes and signs form.
- 2 Attach copy of Signed Consent
- 3 Attach copies of current IEP & any recent reports that may be relevant
- 4 Send to PAC PACES Office: Attention Debbie Crothers [dcrothers@pilgrimac.org](mailto:dcrothers@pilgrimac.org)

#### Requested By

District: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Signature: \_\_\_\_\_

#### Time Line for Testing and review meeting

Completion for all reports:  
 (30 school days) \_\_\_\_\_  
 Meeting to be scheduled by:  
 (45 school days) \_\_\_\_\_

#### Reason for Referral or Referral Question:

\_\_\_\_\_

#### Student Information

Name: \_\_\_\_\_  
 Parent / Guardian: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Town/Zip: \_\_\_\_\_  
 Mom Cell: \_\_\_\_\_  
 Mom Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
 Gender: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Dad Cell: \_\_\_\_\_  
 Dad Work: \_\_\_\_\_

#### School Information

Current School: \_\_\_\_\_  
 Current Grade: \_\_\_\_\_  
 SASID/LASID#: \_\_\_\_\_

#### Contact Person at school

Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

#### Assessment(s) to be completed by PACES

Home Assessment	
Functional Behavior Home	
Functional Behavior School	
Transition Assessment	
Social Cognitive/Skills	
College Readiness	
ABLLS	
Risk	

Neuropsychological	
Psycho-Educational	
Psychological	
Personality	
Educational	
Sensory Intergration & Praxis Rest (SIPT)	
Assistive Technology	
Therapy (circle one) OT PT SLP Reading	

Other (specify) \_\_\_\_\_