TEMPLATE TO REQUEST

INDIVIDUAL EDUCATIONAL EVALUATION

Parent/Parents’ Names

Address

Phone Number

Date

NAME OF SPED DIRECTOR

Special Education Department

SCHOOL DISTRICT NAME

ADDRESS

CITY, STATE ZIP

Fax # (Always send requests such as these via fax and certified mail)

Re: Request for Comprehensive Evaluation

[CHILD’S NAME, DOB]

Dear [NAME OF YOUR DISTRICT’S SPECIAL EDUCATION DIRECTOR]:

This letter serves as our written request for an Independent Educational Evaluation (IEE) consisting of a comprehensive evaluation in all areas of suspected disability at public expense for our child, [child’s full name] pursuant to 34 C.F.R. 300.502(a)(1). [CHILD’S NAME] is a [GRADE] grader at [NAME OF SCHOOL] in a [DESCRIBE PROGRAM] and is eligible for special education under *[list all eligibility categories: visual impairment, OHI, orthopedic impairment, specific learning disability, e.g.*].

As a reminder, [CHILD] underwent a hemispherectomy (a procedure where half the brain is disconnected, and certain portions removed, or half the brain is removed in its entirety) in an attempt to stop drug-resistant seizures) in [YEAR] at age [AGE AT TIME OF SURGERY ]. Thankfully, [CHILD’S NAME] has been seizure free since then. – *if applicable, or other relevant medical information, e.g.:* *has also been diagnosed with hydrocephalus (e.g. shunted at age 7), homonymous hemianopsia, hemiplegia, central auditory processing disorder (CAPD), social communication disorder (SCD), autism, etc.]*

Our request is because we disagree with the school district’s evaluations for several reasons including, but not limited to, that **they failed to address all areas of suspected disability[[1]](#footnote-0)**, were restrictive in their scope, and are thus inappropriate and invalid. [ADD MORE DETAIL IF RELEVANT]

*[i.e.: the evaluation report contains inconsistent statements; evaluation materials were not administered by trained and knowledgeable personnel; the evaluation results are inconsistent with prior evaluations; the evaluation was not sufficiently comprehensive to identify all of my child’s special education and related service needs pursuant to 34 CFR §§300.304 through 300.306; the evaluation did not gather sufficient functional, developmental and academic information about my child to assist the IEP team in determining the content of my child’s IEP; the evaluation did not include assessment tools and strategies that provide relevant information to directly assist the IEP team in determining and addressing the educational needs of my child; assessment was not administered in the child’s native language, etc..] [Provide examples if possible to illustrate the problems you state.]*

There are a number of assessments that are crucial to understanding [CHILD’S NAME]’s very unique profile of strengths and weaknesses. Please see the attached letter from [HIS/HER] neurologist describing the permanent, unavoidable side effects from the disconnection of the [LEFT/RIGHT] hemisphere of [HIS/HER] brain, which also supports the need for the requested assessments.

In total, we request that the following assessments are completed to ensure a comprehensive evaluation:

* Health
* Neuropsychological (including social emotional)
* Educational
* Literacy
* Audiology
* Vision
* Orientation and mobility
* Speech and language
* Assistive Technology
* Gross motor/PT
* Fine motor/ Sensory / Perceptual (OT)
* Educationally Related Mental Health
* Individual Transition Plan (ITP) [age 14 and above]
* Functional life skills / adaptive functioning [age 14 and above]

Here are details about the requested assessments and why each is needed:

* **Basic health**: including hearing and visual acuity, emergency seizure plan, complex care or IHP, and hydrocephalus awareness plan.
* **Neuropsychological**: Due to [CHILD’S NAME]’s brain injury, it is critical that a neuropsychologist (with specialized knowledge of brain surgery for epilepsy and its effects) assess [HIS/HER] multiple domains of impairment and cognitive consequences of hemispherectomy including: learning and memory; attention; speeded information processing; spatial cognitive skills; executive functioning (including initiation, inhibitory control, planning, mental flexibility, and utilization of feedback, which are employed in service of solving problems and reaching future goals); communication and language; nonverbal and auditory processing; visual-motor and visual processing; social-emotional functioning; general cognitive ability; and any new learning problems, to pinpoint specific areas of deficit and instructional needs. This assessment should be executed by a clinician who can work with the school team to offer expert guidance to teachers regarding effective teaching methods and supports for [CHILD’S NAME].

It is important to assess [CHILD’S NAME]’s neurodevelopment, which will have an atypical pattern due to the intractable epilepsy and the radical brain surgery. What areas are improving but still weak, and what areas have significant deficits? This is relevant in understanding how [CHILD’S NAME] is learning, but also what coping mechanisms may be in play, how can [HIS/HER] utilize them maximally to improve [HIS/HER] everyday performance in and out of the classroom, and in adjusting accommodations so that they are useful and effective. We do not want to continue focusing energy and time on areas that have already improved when other areas may be in greater need.

* **Educational:** to assess [CHILD’S NAME]’s academic skills in math, reading, spelling, oral and written expression, and how these skills are impacted by the brain-based issues outlined above. We need to understand any gains [HE/SHE] may have made, or any new areas of deficit, to ensure that he is receiving the most appropriate supports, services and accommodations.
* **Reading assessment:** Due to [CHILD’S NAME]’s well-documented challenges and lack of progress in reading, and the known deficits in literacy (difficulty with reading acquisition and comprehension) after hemispherectomy, we request a comprehensive reading assessment to assess [HIS/HER] literacy/pre-literacy skills, including phonological and phonemic awareness, receptive and expressive vocabulary, comprehension, decoding, and fluency. It is important for the assessor (psychologist or reading specialist) to understand the extent of the auditory impairments related to hemispherectomy, how these may affect evaluation (including considerations of fatigue and that he may require more than one session to complete evaluations) and what accommodations will be necessary. It is also critical to consider the implications of the child’s homonymous hemianopsia (including loss of half the central/foveal field and the entire [RIGHT/LEFT] parafoveal field), including particular visual information processing, visuospatial attention and eye-movement control during reading. The evaluator should have an advanced understanding of the basics of hemianopic dyslexia and its rehabilitation also increases our knowledge about normal reading and its underlying neural mechanisms. Because reading depends critically on the cortical–subcortical network subserving the integration of visual, attentional and oculomotor processes involved in text processing, the assessor should be well-versed in the cortical pathways of literacy.
* **Audiology:** We request a central auditory evaluation to examine the remaining hemisphere's ability to localize, lateralize, and discriminate sounds and recognize auditory patterns. A comprehensive audiological evaluation will determine the extent of [CHILD’S NAME]’s central hearing loss (also known as cortical auditory impairment or central auditory processing deficit). Assessments should include sound in quiet, sound in noise, filtered sound, frequency (pitch) patterns, and dichotic listening. Only audiologists can diagnose CAPD.
  + Research on children post-hemispherectomy indicates that **all** have some degree of cortical auditory impairment. These children often have audiological symptoms but normal pure tone audiograms. They will do well on “sound in quiet” tests (where they listen to different environmental sounds and words, without ear phones, in a soundproof booth); however, when there is competing noise from the environment (“sound in noise”) or environmental sounds or words coming into both ears at the same time (“dichotic listening”) hearing is severely impaired. It is important to note here that all children after hemispherectomy in every published research paper on this subject had auditory processing disorder. [[2]](#footnote-1) [[3]](#footnote-2) [[4]](#footnote-3) [[5]](#footnote-4)
  + Accurate diagnosis is critical because verbal information processing problems can arise from an auditory processing problem, a language processing problem, a combination of both types of processing problems, and/or deficits in cognitive decision making, memory, attention or emotional factors. It is imperative that a qualified examiner (using a sound booth) performs separate testing of each ear, binaural testing and testing in the sound field. The CAP tests stress the auditory system more extensively than a peripheral hearing evaluation.
* **Speech and language:** to assess [CHILD’S NAME]’s speech, articulation, spoken and non-spoken language and communication skills. *[give examples, e.g.: [child's name] has receptive and expressive language deficits, as well as difficulties with sustained attention and error awareness (which may contribute to pragmatic weaknesses).]* Since [CHILD’S NAME] also has [SUSPECTED/CONFIRMED] CAPD, a comprehensive battery of testing to determine the scope of his linguistic deficits is warranted. *OR (children post-hemispherectomy often present with pragmatic language weaknesses as well as receptive and expressive language deficits. Difficulties with sustained attention and error awareness may also contribute to pragmatic weaknesses);*
* **Vision**: [CHILD’S NAME] has a [RIGHT/LEFT] homonymous hemianopsia, a type of cortical vision impairment that includes a loss of half the foveal (central) field and the entire opposite parafoveal field in both eyes. We request a comprehensive assessment to determine how [CHILD’S NAME] uses his remaining vision in everyday life, and to identify areas of concern (for example: in safety, navigation, and reading). [RIGHT/LEFT] hemianopsia, which results after left hemispherectomy, can have a severe impact on reading left to right (because the right half of the central field of vision and the entire right parafoveal field are gone). After hemispherectomy, components of a comprehensive vision assessment should include: visual acuity; field of vision; contrast sensitivity; oculomotor control (including saccades and tracking, analyzing reading from left to right); and depth perception, with consideration of his hemispatial neglect, and visual processing difficulties.
* **Orientation and mobility:** to assess how the homonymous hemianopsia affects his ability to travel safely both indoors and outdoors, with or without assistance, and consider sensory, navigational, visual, and mobility skills. [CHILD’S NAME]’s orientation skills are particularly affected by his hemianopsia and right hemispatial neglect. *[give examples, e.g.: [child's name] often bumps into things or trips on objects on the floor that are in his left field, has fallen off of curbs due to reduced depth perception, and he may be startled when something suddenly appears in his remaining field of vision.]*
* **Physical Therapist/Gross motor:** to examine [CHILD’S NAME]’s locomotor skills, body coordination, ambulation, balance, vestibular reflexes, as well as agility, core strength and postural control. The hemispherectomy disconnected his motor strip and left him with [RIGHT/LEFT] hemiparesis and [RIGHT/LEFT] hemispatial neglect.
* **Occupational Therapist:** 
  + **Fine motor:** to examine object control, specifically in the areas of fine manual control, visual-spatial, visual-motor and fine motor skills. *[give examples, e.g.: In addition to his* [Right/left] *hemiparesis, [child's name] displays dysgraphia and tremors in his* [RIGHT/LEFT] *hand (disconnection of the motor strip impacts both the contralateral and ipsilateral pathways).]*
  + **Sensory evaluation:** to measure the sensory integration processes that underlie learning and behavior, including proprioception, self-regulation and self-modulation. The hemispherectomy surgery removed the sensory cortex of the right side of his brain, and [CHILD’S NAME] displays numerous sensory processing issues (tactile, auditory, visual, etc.). [[6]](#footnote-5)
* **Augmentative Assistive Communication:** to examine what aids and devices can help improve [CHILD’S NAME]’s communication.
* **Assistive Technology:** to further assess what aids and devices can enhance [CHILD’S NAME]’s communication/writing, help him maintain focus, provide access to his curriculum, minimize the academic demands on [CHILD’S NAME] via these resources if possible so as to free up cognitive resources for richer learning. We request that [CHILD’S NAME] receives an Assistive Technology assessment in conjunction with a vision specialist so that during the evaluation there is consideration and understanding of the significant visual field loss (homonymous hemianopsia) as a result of the hemispherectomy. In addition, consulting with [CHILD’S NAME]’s Occupational Therapist to address the motor deficit (hemiparesis) in his customary environment. [CHILD’S NAME] has a significant reading disability as well as problems with visual processing that may affect his math skills. A thorough examination of assistive supports is warranted.
* **Adaptive physical education:** to assess [CHILD’S NAME]’s ability to participate in the school’s physical education program and access the school environment, especially related to health and well-being, as well as functional gross motor skills training in relation to mobility and play, endurance and conditioning programs for physical fitness, balance, body awareness, environmental adaptations, accommodations, and adaptive techniques.
* **School mental health services:** to determine whether [CHILD’S NAME]’s disability may be serious enough to warrant special mental health and therapeutic interventions to enable him to make friends, socialize appropriately, develop self esteem. *(give examples, i.e: [child's name] does not have any friends. He does not feel good about himself. He seems frustrated, demoralized and disoriented from the world.)*
* **Functional behavior assessment:** to assess the purpose/reason for behaviors displayed by children with cognitive or communication disabilities; This request is because [CHILD’S NAME] has exhibited *(list some examples, i.e. multiple off task behaviors, refusals, elopement, etc.). (i.e.: we receive frequent calls from school regarding his behavior. He has been removed from classes multiple times due to ‘behavior issues’ but it has not been made clear what these behavior issues are, nor are there strategies in place to determine how to address those behaviors. The school does not have a plan on how to deal with his refusals or elopement*. *In addition, <child’s name> has challenges in the area of his social and emotional needs. <child’s name> struggles with friendships and has difficulty reaching out to peers, especially in new or unfamiliar environments. He plays alone if he does not know others and has difficulty entering and exiting play.* In order to meet his needs and support him appropriately, we all need to understand the function of his behaviors and why he is making these choices.)
* **Individual Transition Plan (ITP)**: As [CHILD’S NAME] prepares to go into high school, we need to understand his goals and how they align with his potential. Adolescents with neurological impairments like [CHILD’S NAME] need more time to learn skills, including those related to postsecondary transition, so starting this process early will ensure potential success. We should begin collecting information on his strengths, needs, preferences, and interests as they relate to the demands of current and future living, learning, and working environments. We need to understand ways to focus on improving [CHILD’S NAME] academic and functional achievement and ensure that supports and services are in place to facilitate his movement from school to post-school activities.
* **Life Skills/Adaptive Functioning**: to assess [CHILD’S NAME] skills, knowledge, and awareness in daily living, self care, relationships and communication, housing and money management, relationships and communication, career and education planning, and looking forward.

We understand that the school must pay for the independent evaluation unless it can prove in a due process hearing that its evaluation is comprehensive and appropriate[[7]](#footnote-6). Please inform us in writing, without unnecessary delay, whether you intend to honor our request or to request a hearing on the issue.

Please send us your criteria regarding credentials for qualified examiners. We are looking forward to receiving your list of suggested sources and locations, procedures for reimbursement, as well as to arrange a reasonable, expected cost. We are aware that we are not restricted to your suggested sources but will, of course, inform you as soon as we make our decision.

It is also our understanding that the independent evaluator(s) will forward their evaluation reports to you because you are paying for evaluation, that you will schedule an IEP Team meeting for us to discuss the results of said independent evaluation, and that the new evaluation must be considered in any future decisions about our child.

We trust that the assessments will be performed by qualified individuals and that the testing protocols used will be appropriate for a child with [CHILD’S NAME] vision, hearing, orthopedic, fine motor, and attention challenges. Each evaluator should have an understanding of the following:

* Homonymous hemianopsia (including the loss of half the central/foveal field and the entire [RIGHT/LEFT] parafoveal field), including visual information processing, visuospatial attention and eye-movement control issues (examiner should be seated on [CHILD’S NAME]’s [RIGHT/LEFT] and present materials in his [RIGHT/LEFT] central field of vision);
* Central Auditory Processing Deficit (assessor should speak into his [RIGHT/LEFT] ear; he should be assessed in a silent room unless the test is to measure his ability to function in a multiple noise environment or how his abilities may be impacted in typical environments);
* Motor deficit ([RIGHT/LEFT] hemiparesis): some assessment measures expect a student to have bilateral hand use. The results of these assessments should reflect his struggles and needs for further adaptation;
* Attention deficits;
* Social communication (pragmatic) deficits.

We request an assessment process that yields the most effective teaching methods and supports for [CHILD’S NAME]; that the evaluator be well-versed in extending the assessment beyond office-bound tests. What can [CHILD’S NAME] do independently? What can [HE/SHE] do in the classroom? How does he function in real-world settings not just 1:1 in an assessment setting (where his prefrontal cortex is optimally supported, and [HIS/HER] most serious disabilities may be overlooked by the evaluator)?

*“Prefrontal brain injury often necessitates creative deviation from traditional school assessment policies to ensure that needed services and supports are provided (e.g., going beyond standardized tests and fixed performance criteria to determine eligibility for services).[[8]](#footnote-7)”*

We are eager to move forward with this plan so that we can put together an appropriate educational program for our child.

Sincerely,

[Parents names]

cc:

[principal, case manager, district sped coordinator, and any advocates or other relevant team members]

1. The State must ensure that in evaluating each child with a disability under 34 CFR §§300.304 through 300.306, the evaluation is sufficiently comprehensive to assess the child in all areas related to the suspected disability, and must identify all of the child's special needs, whether or not commonly linked to the disability category in which the child has been classified. 34 CFR §300.304(e)(4)and (6). [↑](#footnote-ref-0)
2. [J Child Neurol.](http://www.ncbi.nlm.nih.gov/pubmed/12731649#) 2003 Mar;18(3):228-32.

   Auditory processing studied prospectively in two hemidecorticectomy patients.

   [Boatman D](http://www.ncbi.nlm.nih.gov/pubmed/?term=Boatman%20D%5BAuthor%5D&cauthor=true&cauthor_uid=12731649)1, [Vining EP](http://www.ncbi.nlm.nih.gov/pubmed/?term=Vining%20EP%5BAuthor%5D&cauthor=true&cauthor_uid=12731649), [Freeman J](http://www.ncbi.nlm.nih.gov/pubmed/?term=Freeman%20J%5BAuthor%5D&cauthor=true&cauthor_uid=12731649), [Carson B](http://www.ncbi.nlm.nih.gov/pubmed/?term=Carson%20B%5BAuthor%5D&cauthor=true&cauthor_uid=12731649). [↑](#footnote-ref-1)
3. [J Am Acad Audiol.](http://www.ncbi.nlm.nih.gov/pubmed/24047941#) 2013 Jul-Aug;24(7):535-43. doi: 10.3766/jaaa.24.7.2.

   Auditory processing following consecutive right temporal lobe resections: a prospective case study.

   [Nagle S](http://www.ncbi.nlm.nih.gov/pubmed/?term=Nagle%20S%5BAuthor%5D&cauthor=true&cauthor_uid=24047941)1, [Musiek FE](http://www.ncbi.nlm.nih.gov/pubmed/?term=Musiek%20FE%5BAuthor%5D&cauthor=true&cauthor_uid=24047941), [Kossoff EH](http://www.ncbi.nlm.nih.gov/pubmed/?term=Kossoff%20EH%5BAuthor%5D&cauthor=true&cauthor_uid=24047941), [Jallo G](http://www.ncbi.nlm.nih.gov/pubmed/?term=Jallo%20G%5BAuthor%5D&cauthor=true&cauthor_uid=24047941), [Boatman-Reich D](http://www.ncbi.nlm.nih.gov/pubmed/?term=Boatman-Reich%20D%5BAuthor%5D&cauthor=true&cauthor_uid=24047941). [↑](#footnote-ref-2)
4. [Neuropsychologia.](https://www.ncbi.nlm.nih.gov/pubmed/17512023#) 2007 Jun 18;45(11):2461-6. Epub 2007 Apr 8.

   Dichotic listening after cerebral hemispherectomy: methodological and theoretical observations.

   [de Bode S](https://www.ncbi.nlm.nih.gov/pubmed/?term=de%20Bode%20S%5BAuthor%5D&cauthor=true&cauthor_uid=17512023)1, [Sininger Y](https://www.ncbi.nlm.nih.gov/pubmed/?term=Sininger%20Y%5BAuthor%5D&cauthor=true&cauthor_uid=17512023), [Healy EW](https://www.ncbi.nlm.nih.gov/pubmed/?term=Healy%20EW%5BAuthor%5D&cauthor=true&cauthor_uid=17512023), [Mathern GW](https://www.ncbi.nlm.nih.gov/pubmed/?term=Mathern%20GW%5BAuthor%5D&cauthor=true&cauthor_uid=17512023), [Zaidel E](https://www.ncbi.nlm.nih.gov/pubmed/?term=Zaidel%20E%5BAuthor%5D&cauthor=true&cauthor_uid=17512023). [↑](#footnote-ref-3)
5. [Brain Res Cogn Brain Res.](https://www.ncbi.nlm.nih.gov/pubmed/16169196#) 2005 Oct;25(2):537-46. Epub 2005 Sep 16.

   Sound lateralization in subjects with callosotomy, callosal agenesis, or hemispherectomy.

   [Hausmann M](https://www.ncbi.nlm.nih.gov/pubmed/?term=Hausmann%20M%5BAuthor%5D&cauthor=true&cauthor_uid=16169196)1, [Corballis MC](https://www.ncbi.nlm.nih.gov/pubmed/?term=Corballis%20MC%5BAuthor%5D&cauthor=true&cauthor_uid=16169196), [Fabri M](https://www.ncbi.nlm.nih.gov/pubmed/?term=Fabri%20M%5BAuthor%5D&cauthor=true&cauthor_uid=16169196), [Paggi A](https://www.ncbi.nlm.nih.gov/pubmed/?term=Paggi%20A%5BAuthor%5D&cauthor=true&cauthor_uid=16169196), [Lewald J](https://www.ncbi.nlm.nih.gov/pubmed/?term=Lewald%20J%5BAuthor%5D&cauthor=true&cauthor_uid=16169196). [↑](#footnote-ref-4)
6. Dijkerman, HC. et al. Ipsilesional and contralesional sensorimotor function after hemispherectomy: differences between distal and proximal function. Neuropsychologia. 2008 Feb 12;46(3):886-901 [↑](#footnote-ref-5)
7. *When an evaluation is conducted in accordance with 34 CFR §§300J04 through 300.311 and a parent disagrees with the evaluation because a child was not assessed in a particular area, the parent has the right to request an lEE to assess the child in that area to determine whether the child has a disability and the nature and extent of the special education and related services that child needs.* [↑](#footnote-ref-6)
8. http://www.projectlearnet.org/tutorials/psych\_and\_neuro\_assessment.html [↑](#footnote-ref-7)