

District Name:

Address:

# REVIEW OF EXISTING DATA (RED)



**NAME OF CHILD:**  
**STATE TESTING NUMBER (STN):**  
**IEP TEACHER OF RECORD:**

**GRADE:**  
**STUDENT ID:**  
**DISTRICT/AGENCY:**

**BIRTHDATE:**  
**AGE:**

**BUILDING:**

**SITE CODE:**

**PARENT(S):**

**HOME ADDRESS:**

**PHONE: (WORK):**

**(HOME)**

**(OTHER)**

**Date of Data Review:**

<b>SPECIFY PRESENTING CONCERNS:</b>	
Other Presenting Concerns:	
<b>This data review is for:</b>	<input type="checkbox"/> Initial evaluation <input type="checkbox"/> Reevaluation <input type="checkbox"/> Out of State Transfer <input type="checkbox"/> Functional Behavior Evaluation
<b>BACKGROUND INFORMATION</b>	
<b>Native Language/Mode of Communication:</b>	
<b>Primary Language of Home:</b>	
<b>Number of Schools Previously Attended:</b>	
<b>List Grade(s) Repeated:</b>	
<b>Remedial/Other School Services:</b>	
<b>Previous Individualized Evaluation(s)/Date(s):</b>	

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<b>Currently Receives Special Education Services:</b>	<b>Eligible Under:</b>
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**Review by a group of qualified professional and parent(s) does not require a meeting (34 CFR § 300.305)**

<b>Previously Received Special Education Services:</b>			
<b>Currently Receives 504 Services:</b>			
<b>Previously Received 504 Services:</b>			
<b>Student Received SoonerStart:</b>		<b>Other Intervention Services:</b>	
<b>Service(s) Provided By Outside Professional/Agency:</b>			
<b>TEAM/GROUP RECOMMENDED ACTION BASED ON THE REVIEW OF EXISTING DATA:</b>			
Date of consent for evaluation			
Additional Assessments are Necessary for Initial Evaluation			
Additional Comments:			
Justification/Recommendations:			
Suspected Primary Disability Category(ies):			

<b>DOCUMENTATION OF INTERVENTIONS:</b>		
<b>Targeted Behavior/Skill:</b>		
<b>Goal(s):</b>	<b>Was goal accomplished?</b>	<b>Recommended Action:</b>
<b>Interventions Attempted/Services Provided:</b>		
<b>Frequency and Duration:</b>		

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<b>Treatment Integrity Data:</b>	
<b>Type of Measure Used to Define Outcome:</b>	Measure:
	Outcome:

**VISION AND HEARING EVALUATION INFORMATION:**

<b>VISION INFORMATION</b>	<b>HEARING INFORMATION</b>
<b>Any Concerns Regarding the Student's Vision?:</b>	<b>Any Concerns Regarding the Student's Hearing?:</b>
<b>Explanation:</b>	<b>Explanation:</b>
<b>Date of Last Vision Test:</b>	<b>Date of Last Hearing Test:</b>
<b>Results of Findings:</b>	

**TEAM/GROUP RECOMMENDED ACTION BASED ON THE REVIEW OF EXISTING DATA:**

Date of consent for evaluation
Additional Assessments are Necessary for Initial Evaluation
Additional Comments:
Justification/Recommendations:
Suspected Primary Disability Category(ies):

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**SIGNATURES:**

Special Education Teacher \_\_\_\_\_ Date \_\_\_\_\_

Administrative Representative \_\_\_\_\_ Date \_\_\_\_\_

Other/Qualified Professional \_\_\_\_\_ Date \_\_\_\_\_

Other/Qualified Professional \_\_\_\_\_ Date \_\_\_\_\_

Parent(s) \_\_\_\_\_ Date \_\_\_\_\_

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**OTHER MEETING PARTICIPANTS**

Signature	Printed Name	Date	Purpose