Your Educational Partner of Choice
BOCES 2
Monroe 2- Orleans Board of Cooperative Educational Services

REQUEST FOR INITAL SERVICE OR EVALUATION (R.I.S.E.) *Formerly 89F Request*

Student's Legal Name: _____ DOB: _____ Grade: _____ Pronouns Used: _____

Student is Also Known As: _____

Classroom (Building): _____ Teacher: _____ Billing District: _____

Referred by: _____ Position: _____ Date of Form Completion: _____

Parent(s)/Guardian(s): _____

Address: _____

_____

Parent Phone/Email: _____

_____

Recommendations/Notes: *(BOCES 2 Evaluator/Office Support use only)*

Current BOCES Program:

☐ Preschool Integrated	☐ 6:1:1 Complex Needs	☐ 12:1:2 (K-2; 9-12)
☐ Preschool 8:1:3	☐ 6:1:1 Medically Fragile	☐ 6:1:2 Complex Needs
☐ 6:1:2 ASD	☐ 6:1 1 Center-Based	☐ Transition (12:1:1/6:1:1)
	☐ 8:1:1 CaSS	

Or, Current Placement:

☐ In-District
☐ Parentally Placed
☐ District Placed

Classified/504 Plan:

Yes ☐ No ☐ 504 Plan ☐

1. **Check requested:** ☐ Student Evaluation and/or ☐ Service Request For ☐ Current or ☐ Upcoming School Year

☐ Assistive Technology	☐ Audiology Services	☐ Autism Services	☐ Consultant Teacher
☐ Counseling Services	☐ Hearing Impaired/TOD	☐ Functional Behavior Assessment**	☐ Resource Room
☐ Occupational Therapy	☐ Orientation & Mobility	☐ Physical Therapy	☐ Art Therapy
☐ Psychological	☐ Transition Services	☐ Speech/Language	☐ Music Therapy
☐ Vision	☐ Work-Based Learning	☐ Other Evaluation not listed: _____	

Please note: Functional Behavior Assessments should only be completed for students in a current BOCES Program

2. **Reason for referral:** Provide specific information as to the purpose of this request in box below and any additional evaluation information

3. **Reevaluation Consideration:** ☐ The team has reviewed the student and is not recommending any further evaluations at this time. (No Reevaluation)

CSE Signature: _____ Date: _____ **Parent Consent:** ☐ Attached ☐ To be Obtained (Forward to BOCES)

Anticipated CSE Date, or "no later than" timeline: _____

BOCES 2 Program Administrator Signature: _____ Date: _____

Chair-assigned Evaluator/Service Provider: _____

Will the Home School District and/or Receiving School be completing any additional evaluations?