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PSYCHOLOGICAL TESTING

Student Name: _____ Date: _____

I/We understand that full disclosure of all psychological/psychiatric/educational testing and treatment history is critical to the appropriate service provision for my student. Therefore:

** Please choose one option by placing your initials in the box next to the appropriate response.*

_____ I have enclosed copies of my child's earliest testing, current testing, IEP/504 Plan, and reports from other professionals (psychiatric, psychological, educational or medical).

_____ I have signed the Student Transcript Request for Spectrum College Transition Program to obtain records for my student: Educational History and Professional Reports.

_____ I do not have access to current testing IEP/504 Plan, and reports from other professionals, and so have enclosed a check to Spectrum College Transition Program and have completed the following consent to have testing and evaluation done.

CONSENT TO ADMINISTER PSYCHOLOGICAL AND/OR EDUCATIONAL TESTING

I hereby agree to psychological testing for the student named below. I understand that all test protocols and all material generated from the assessment are the property of Spectrum College Transition Program. I understand that information may come to light during this evaluation that must remain confidential, due to the content of the disclosure. I understand that the results of the assessments will be used by the staff of Spectrum College Transition Program to enhance the service provision of the student. Finally, I understand that no information will be shared with anyone else, or any other agency, without my permission.

_____ Yes, Please have my student evaluated at an additional cost of \$_____ to be paid by:

Name of Student: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____