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Dear Parent,

Your child is scheduled for an auditory processing evaluation at Tampa Children's ENT.

Please make sure your child is well rested and has eaten normal meals the day of his/her appointment. You may also bring a few snacks for your child to eat during breaks in testing. If your child gets cold at doctor's offices, please bring a sweater for your child to wear at the appointment to ensure he/she is comfortable during testing.

Please complete the enclosed paperwork and checklists to the best of your ability and bring them with you to your child's appointment. These checklists will not be used for the diagnosis of an auditory processing deficit, but will help the audiologist understand your child's difficulties and your concerns. It will also help the audiologist make recommendations specific to your child's needs.

If your child has been diagnosed with any attention issues and is currently taking medication to manage the attention issue, it is very important that your child take this medication on the day of testing to ensure that he/she can focus throughout the testing. If your child cannot sustain attention long enough to complete the testing, the audiologist may not be able to determine if your child has an auditory processing disorder.

If your child has completed a speech and language evaluation and/or a psycho-educational or neuro-psychological evaluation, please bring a copy of these evaluations with you prior to your child's appointment. If possible, it is extremely beneficial to have these evaluations completed prior to the auditory processing evaluation.

Please note that your child must be 7 years of age or older, have a normal IQ (intelligence), be English speaking, and have normal hearing in both ears. Your child's hearing will be tested prior to the auditory processing evaluation to confirm that he/she has normal hearing on the day of testing. An auditory processing evaluation cannot be completed on children with any of the following diagnoses: severe developmental delay, Autism, Asperger's, Pervasive Developmental Disorder, or hearing loss. If you have questions regarding your child's candidacy for an auditory processing evaluation, please call 813-262-1330 and ask to speak with the audiologist prior to your child's appointment.

I look forward to working with you and your child!

Sincerely,

Pediatric Audiology Team

PLEASE COMPLETE FORMS BELOW



NOTE: PLEASE **DO NOT** FILL IN YOUR CHILD'S NAME OR DATE OF BIRTH PRIOR TO ARRIVING AT APPOINTMENT

Patient Information

Gender: M or F

Address: _____ City: _____ State: _____

Primary Phone: (____)____-____ Secondary Phone: (____)____-____

Primary Care Physician: _____ Physician Phone: (____)____-____

Pharmacy: _____ Pharmacy Phone: (____)____-____

Additional providers to receive reports:

Physician: _____ Physician Phone: (____)____-____

Physician: _____ Physician Phone: (____)____-____

Who has legal custody/guardianship of the patient?

Parents Grandparent/Other Relative (specify): _____

Mother Only Foster Parent: _____

Father Only State Custody/Other (specify): _____

Mother's Information

Last Name: _____ First: _____ Age: _____

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

(if different from child)

Primary Phone: (____)____-____ Secondary Phone: (____)____-____

Occupation: _____ Work Phone: (____)____-____

Father's Information

Last Name: _____ First: _____ Age: _____

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

(if different from child)

Primary Phone: (____)____-____ Secondary Phone: (____)____-____

Occupation: _____ Work Phone: (____)____-____

Emergency Contacts (please provide 2)

Name: _____ Phone: (____)____-____ Relationship: _____

Name: _____ Phone: (____)____-____ Relationship: _____



PATIENT HISTORY

Date of Visit: _____ / _____ / _____

Who referred your child for an auditory processing evaluation: _____

Reason for Visit:

Birth History

How many weeks was your child at birth? _____ weeks

Where was your child born? _____

Please list any complications with pregnancy or delivery: _____

Did your child stay in the NICU? Yes No

If yes, how long was the NICU stay? _____

Did your child pass the newborn hearing screening? Yes No

If no, which ear(s)? Right Left Both

Was your child jaundice: Yes No

If yes, what treatment was used? Photo Therapy Blood Transfusion Sunlight

Did your child receive IV antibiotics? _____ If yes, when: _____

Medical History

Please list past medical problems or diagnoses. Check here if NONE

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Problem/Diagnosis: _____ Date Diagnosed: ____/____/____

Please list any specialist physicians caring for your child. Check here if NONE

Physician Name: _____ Specialty: _____ Reason: _____

Physician Name: _____ Specialty: _____ Reason: _____

Physician Name: _____ Specialty: _____ Reason: _____

Please list any hospitalizations. Check here if NONE

Date of Hospitalization ____/____/____ Reason for Hospitalization: _____

Date of Hospitalization ____/____/____ Reason for Hospitalization: _____

Date of Hospitalization ____/____/____ Reason for Hospitalization: _____



Medications

Please list all current medications your child is taking. Check here if NONE

Medication Name: _____ Dose: _____ Reason: _____

Is your child taking medication for attention difficulties? Yes No

Having you noticed change in attention since he/she started the medication? Yes No

Family History:

Please list all members living in the child's household (i.e. mother, father, etc.)

First Name: _____	Relationship: _____	Age: _____	Related Diagnosis: _____
First Name: _____	Relationship: _____	Age: _____	Related Diagnosis: _____
First Name: _____	Relationship: _____	Age: _____	Related Diagnosis: _____
First Name: _____	Relationship: _____	Age: _____	Related Diagnosis: _____
First Name: _____	Relationship: _____	Age: _____	Related Diagnosis: _____
First Name: _____	Relationship: _____	Age: _____	Related Diagnosis: _____

***Related diagnoses may include ADHD, PDD, ODD, Hearing loss, etc.**

Developmental History:

What hand does your child write with? Right Left

At what age did your child crawl? _____

At what age did your child walk? _____

At what age did your child say his/her first word? _____

Were there any delays in your child's development? Yes No

If yes, explain: _____



Audiology History:

Do you feel that your child hears well? Yes No

Do you think your child has a problem listening or understanding? Yes No

Does anyone in the family have a hearing loss? Yes No

If yes, explain: _____

Are you or someone else concerned about your child's speech? Yes No

Has your child been diagnosed with Autism, Asperger's, or Pervasive Developmental Disorder? Yes No

Has your child been diagnosed with a syndrome? Yes No

If yes, what syndrome: _____

Has your child had any ear infections? Yes No

If yes, how many? _____ Date of Last Infection? _____

Has your child had ear surgery (including ear tubes)? Yes NO

If yes, when? _____

Does your child report noise in their ears? Yes NO

If yes, which? Ringing Beeping Clicking Roaring

Does your child report feeling dizzy or off balance? Yes No

Does your child complain of pain in the ears? Yes No

Is your child bothered by background noise or does he/she have difficulty hearing when it's noisy? Yes No



Educational History:

Has your child ever repeated a grade? Yes No
 If yes, which grade? _____ Why? _____

Does your child have difficulty at school? Yes
 If yes, please explain: _____

What subjects does your child struggle with? _____

What subjects does your child excel in? _____

Has your child been tutored? Yes No
 If yes, explain: _____

Is your child receiving special school support (i.e. special ed, pull out services, classroom modifications, etc)?
 Yes No
 Please list all school services: _____

Does your child have a learning disability? Yes No
 If yes, explain: _____

Is there a family history of learning problems? Yes No
 If yes, explain: _____

Evaluation Record:

***Please mark previous evaluations that your child may have had:**

TESTING	YES	NO	AGE EVALUATED	NORMAL RESULTS	ABNORMAL RESULTS
Hearing					
Neurological					
Psychological					
Speech and Language					
Vision					
Occupational (fine motor)					
Physical (gross motor)					



Therapy History:

Does your child receive any school or private therapy services (i.e. speech, physical, occupational)? Yes No

Please list any school or private therapy services:

Therapy Provided: _____ Facility: _____ Duration: _____

Therapy Provided: _____ Facility: _____ Duration: _____

Therapy Provided: _____ Facility: _____ Duration: _____

Behaviors and Characteristics:

Please indicate (x) if your child exhibits any of the following:

- Sensitive to loud sounds
- Difficulty understanding or is confused in noisy places
- Difficulty following and/or understanding TV shows
- Easily upset by new situations
- Difficulty following directions
- Does opposite of what is asked
- Restless, difficulty sitting still
- Overly active
- Short attention span
- Easily distracted
- Daydreams
- Forgetful
- Asks for repetition
- Reverses words, numbers, or letters
- Anxious
- Lacks Motivation
- Does not complete assignments
- Easily frustrated
- Tires easily
- Dislikes school
- Clumsy
- Prefers to play with older children
- Prefers to play with younger children
- Seeks attention
- Disruptive
- Shy
- Lacks self-confidence



Please list any additional information you would like the audiologist to know: _____

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Vision Questionnaire:

- Blur when looking at near
- Headaches with near work
- Words run together when reading
- Burning, itching, watery eyes
- Falls asleep when reading
- Sees worse at the end of the day
- Skips/repeats lines when reading
- Head tilt/close one eye when reading
- Frowns, scowls, or squints to see blackboard
- Avoids near work/reading
- Omits small words when reading
- Writes up/down hill
- Misaligns digits/columns of numbers
- Holds reading too close
- Trouble keeping attention on reading
- Poor handwriting / hand-eye coordination
- Rubs eyes during or after visual activity
- Complains of blur while reading or writing
- Confuses words with similar beginnings or endings
- Uses finger or marker when reading
- Loses place often when reading
- One eye turns (in, out, up, or down)
- Complains of letter or lines "floating," "running together," or "jumping around"





FISHER'S AUDITORY PROBLEM CHECKLIST

Please place a check mark before each item that is considered to be a concern by the observer:

- 1. Has a history of hearing loss.
- 2. Has a history of ear infection(s).
- 3. Does not pay attention (listen) to instruction 50% or more of the time.
- 4. Does not listen carefully to directions—often necessary to repeat instructions.
- 5. Says “Huh?” and “What?” at least five or more times per day.
- 6. Cannot attend to auditory stimuli for more than a few seconds.
- 7. Has a short attention span. (If this item is checked, also check the most appropriate time frame)
 0-2 minutes 3-5 minutes 6-15 minutes 15-30 minutes
- 8. Daydreams – attention drifts – not with it at times.
- 9. Is easily distracted by background sound(s).
- 10. Has difficulty with phonics.
- 11. Experiences problems with sound discrimination.
- 12. Forgets what is said in a few minutes.
- 13. Does not remember simple routine things from day to day.
- 14. Displays problems recalling what was heard last week, month, year.
- 15. Has difficulty recalling sequence that has been heard.
- 16. Experiences difficulty following auditory directions.
- 17. Frequently misunderstands what is said.
- 18. Does not comprehend many words-verbal concepts for age/grade level.
- 19. Learns poorly through the auditory channel.
- 20. Has a language problem, (morphology, syntax, vocabulary, phonology).
- 21. Has an articulation (phonology) problem.
- 22. Cannot always relate what is heard to what is seen.
- 23. Lacks motivation to learn.
- 24. Displays slow or delayed responses to verbal stimuli.
- 25. Demonstrates below average performance in one or more academic areas.

Scoring: Four percent credit for each numbered item not checked.

Number of items not checked ____ x 4 = ____



C. H. A. P. S.

Children's Auditory Performance Scale

by Walter J. Smoski, Ph.D., Michael A. Brunt, Ph.D., J. Curtis Tannahill, Ph.D.

Child's Name _____ Age (years _____ months _____) Date Completed _____
 Name of Person _____
 Completing CHAPS _____ Relationship to Child _____

PLEASE READ INSTRUCTIONS CAREFULLY

Answer all questions by comparing this child to other children of similar age and background. Do not answer the questions based only on the difficulty of the listening condition. For example, all 8-year-old children, to a certain extent, may not hear and understand when listening in a noisy room; this would be a difficult listening condition for all children. However, some children may have more difficulty in this listening condition than others. You must judge whether or not THIS child has MORE difficulty than other children in each listening condition cited. Please make your judgment using the following response choices. CIRCLE a number for each item. For ages 7 and above.

LESS DIFFICULTY
 SAME AMOUNT OF DIFFICULTY
 SLIGHTLY MORE DIFFICULTY
 MORE DIFFICULTY
 CONSIDERABLY MORE DIFFICULTY
 SIGNIFICANTLY MORE DIFFICULTY
 CANNOT FUNCTION AT ALL

LISTENING CONDITION

NOISE

TOTAL CONDITION SCORE

If listening in a room where there is background noise such as TV, music, others talking, children playing, etc., this child has difficulty hearing and understanding compared to other children of similar age and background

- | | | | | | | | |
|--|----|---|----|----|----|----|----|
| 1. When paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 2. When being asked a question | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 3. When being given simple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 4. When being given complicated, multiple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 5. When not paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 6. When involved with other activities, i.e., coloring, reading, etc | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 7. When listening with a group of children | +1 | 0 | -1 | -2 | -3 | -4 | -5 |

COMMENTS:

QUIET

TOTAL CONDITION SCORE

If listening in a quiet room (others may be present, but are being quiet), this child has difficulty hearing and understanding compared to other children of similar age and background.

- | | | | | | | | |
|---|----|---|----|----|----|----|----|
| 8. When paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 9. When being asked a question | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 10. When being given simple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 11. When being given complicated, multiple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 12. When not paying attention | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 13. When involved with other activities, i.e., coloring reading, etc. | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 14. When listening with a group of children | +1 | 0 | -1 | -2 | -3 | -4 | -5 |

COMMENTS:

IDEAL

TOTAL CONDITION SCORE

When listening in a quiet room, no distractions, face-to-face, and with good eye contact, this child has difficulty hearing an understanding compared to other children of similar age and background.

- | | | | | | | | |
|---|----|---|----|----|----|----|----|
| 15. When being asked a question | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 16. When being given simple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 17. When being given complicated, multiple instructions | +1 | 0 | -1 | -2 | -3 | -4 | -5 |

COMMENTS:

MULTIPLE INPUTS

TOTAL CONDITION SCORE

When, in addition to listening, there is also some other form of input, (i.e., visual, tactile, etc.) this child has difficulty hearing and understanding compared to other children of similar age and background.

- | | | | | | | | |
|--|----|---|----|----|----|----|----|
| 18. When listening and watching the speaker's face | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 19. When listening and reading along when material is read aloud by another | +1 | 0 | -1 | -2 | -3 | -4 | -5 |
| 20. When listening and watching someone provide an illustration, such as a model, drawing, information on the overhead projector or chalkboard, etc. | +1 | 0 | -1 | -2 | -3 | -4 | -5 |

COMMENTS:



LISTENING CONDITION

AUDITORY MEMORY SEQUENCING

TOTAL CONDITION SCORE

- If required to recall spoken information, this child has difficulty hearing and understanding compared to other children of similar age and background
21. Immediately recalling information such as a word, word spelling, numbers
 22. Immediately recalling simple instructions
 23. Immediately recalling multiple instructions
 24. Not only recalling information, but also the order and sequence of the information
 25. When delayed recollection (1 hour or more) of words, word spelling, numbers, etc. is required
 26. When delayed recollection (1 hour or more) of simple instructions is required
 27. When delayed recollection (1 hour or more) of multiple instructions is required
 28. When delayed recollection (24 hours or more) is required

	LESS DIFFICULTY	SAME AMOUNT	SLIGHTLY MORE	MORE DIFFICULTY	CONSID. MORE	SIGNIFIC. MORE	CAN'T FUNCTION
21.	+1	0	-1	-2	-3	-4	-5
22.	+1	0	-1	-2	-3	-4	-5
23.	+1	0	-1	-2	-3	-4	-5
24.	+1	0	-1	-2	-3	-4	-5
25.	+1	0	-1	-2	-3	-4	-5
26.	+1	0	-1	-2	-3	-4	-5
27.	+1	0	-1	-2	-3	-4	-5
28.	+1	0	-1	-2	-3	-4	-5

COMMENTS:

AUDITORY ATTENTION SPAN

TOTAL CONDITION SCORE

- If extended periods of listening are required, this child has difficulty paying attention, that is, being attentive to what is being said compared to other children of similar age and background.
29. When the listening time is less than 5 minutes
 30. When the listening time is 5-10 minutes
 31. When the listening time is over 10 minutes
 32. When listening in a quiet room
 33. When listening in a noisy room
 34. When listening first thing in the morning
 35. When listening near the end of the day, i.e., before supper time
 36. When listening in a room where there are also visual distractions

	LESS DIFFICULTY	SAME AMOUNT	SLIGHTLY MORE	MORE DIFFICULTY	CONSID. MORE	SIGNIFIC. MORE	CAN'T FUNCTION
29.	+1	0	-1	-2	-3	-4	-5
30.	+1	0	-1	-2	-3	-4	-5
31.	+1	0	-1	-2	-3	-4	-5
32.	+1	0	-1	-2	-3	-4	-5
33.	+1	0	-1	-2	-3	-4	-5
34.	+1	0	-1	-2	-3	-4	-5
35.	+1	0	-1	-2	-3	-4	-5
36.	+1	0	-1	-2	-3	-4	-5

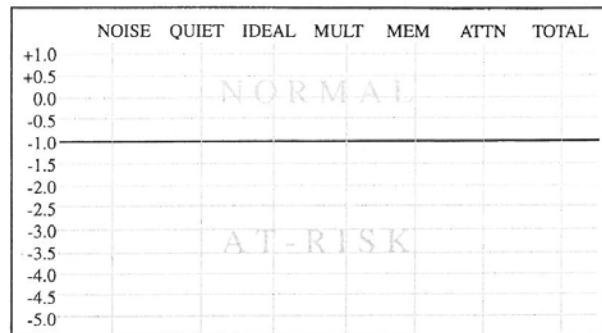
COMMENTS:

SCORING: The CHAPS can be scored two ways. Add the circled responses for each condition and place the sum in the Total Condition Score box in under each listed listening condition. Be careful to note "+" and "-" values when adding. Transcribe these sums as indicated below and determine the average score for each listening condition. The Total Condition Scores can be compared to the indicated PASS and FAIL ranges and the appropriate box checked. In addition, the average condition scores can be plotted on the graph to display performance as compared to the normal range. See the CHAPS manual for more complete validity and interpretation information.

LISTENING CONDITION	TOTAL CONDITION SCORE	AVERAGE CONDITION SCORE	Pass	Risk
NOISE	_____ + 7 = _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
QUIET	_____ + 7 = _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
IDEAL	_____ + 3 = _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
MULTIPLE	_____ + 3 = _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
MEMORY	_____ + 8 = _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
ATTENTION	_____ + 8 = _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL	_____ + 36 = _____	_____	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL CONDITION SCORE:
 PASS RANGE +36 to -11
 AT-RISK RANGE -12 to -130

CHAPS Listening Condition Analysis: Transfer Average Condition Scores by entering "X" on graph (round 0.5 scores up to next decimal).



NOTE: Children who score in the at-risk range on the CHAPS will not necessarily require a special academic support program in school. Research found that 45% of students scoring in the at-risk range required no special support services. 50% of students scoring in the at-risk range had below grade level reading ability. 55% required some type of special support or accommodations to achieve success in school.



Reading Insert Grades 1st-3rd

1. Does the child have difficulty with sound/symbol correspondence (i.e. /a/ as in apple)?

Yes No If yes, list examples:

2. Does the child confuse letters that look alike (i.e. b/d/p, w/m. h/n, f, t)?

Yes No If yes, list examples:

3. Does the child have confusion perceiving letters that have similar sounds (i.e. /f/ vs. /v/, /p/ vs. /b/)?

Yes No If yes, list examples:

4. Does the child have difficulty remembering common sight words (was, the, and, she)?

Yes No

5. Does the child have difficulty segmenting words in sounds (i.e. cat-/k/ /a/ /t/)?

Yes No

6. Does the child have difficulty blending individual sounds to make words?

Yes No

7. Does your child have difficulty with rhyming words (Tell me a word that rhymes with bat)?

Yes No

8. Does the child have reading and spelling errors that indicate difficulty sequencing sounds (i.e. blast read or spelled blats)?

Yes No

9. Does the child demonstrate omission of grammatical endings when reading and writing (-s, -ed, -ing)?

Yes No

10. Does your child have difficulty remembering spelling of words over time?

Yes No



Reading Insert Grades 4th-8th

1. Is there a history of dyslexia in your family?
 Yes No
2. Does the child have significant difficulty reading and spelling multisyllabic/longer words? Omits whole syllables (i.e. complicated spelled as completed or adolescents spelled as adolesense)?
 Yes No
3. Does the child have reduced awareness of word structures (prefix, root, and suffixes)? (i.e. leaves if endings on words -ed, -s, -es, difficulty understanding prefixes (pre-, sub-), difficulty understanding root words and suffixes (i.e. declare/declaration))
 Yes No
4. Does the child demonstrate frequent misreading of common sight words?
 Yes No
5. Does the child have difficulty learning new information from print because of word reading errors?
 Yes No
6. Does the child have difficulty understanding print because of underlying oral language problems with vocabulary and or grammar?
 Yes No
7. Does the child have significant difficulty writing due to spelling and organization problems?
 Yes No
8. Is the child slow in their rate of reading (how fast or slow the child reads)?
 Yes No



Please have your child's
teacher complete the
following 2 pages



S.I.F.T.E.R. SCREENING INSTRUMENT FOR TARGETING EDUCATIONAL RISK

by Karen L. Anderson, Ed.S., CCC-A

STUDENT _____ TEACHER _____ GRADE _____

DATE COMPLETED _____ SCHOOL _____ DISTRICT _____

The above child is suspect for hearing problems which may or may not be affecting his/her school performance. This rating scale has been designed to sift out students who are educationally at risk possibly as a result of hearing problems. Based on your knowledge from observations of this student, circle the number best representing his/her behavior.

After answering the questions, please record any comments about the student in the space provided on the reverse side.

1. What is your estimate of the student's class standing in comparison of that of his/her classmates?	UPPER 5	4	MIDDLE 3	2	LOWER 1	ACADEMICS	<input type="checkbox"/>
2. How does the student's achievement compare to your estimation of her/her potential?	EQUAL 5	4	LOWER 3	2	MUCH LOWER 1		
3. What is the student's reading level, reading ability group or reading readiness group in the classroom (e.g., a student with average reading ability performs in the middle group)?	UPPER 5	4	MIDDLE 3	2	LOWER 1		
4. How distractible is the student in comparison to his/her classmates?	NOT VERY 5	4	AVERAGE 3	2	VERY 1	ATTENTION	<input type="checkbox"/>
5. What is the student's attention span in comparison to that of his/her classmates?	LONGER 5	4	AVERAGE 3	2	SHORTER 1		
6. How often does the student hesitate or become confused when responding to oral directions (e.g., "Turn to page . . .")?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
7. How does the student's comprehension compare to the average understanding ability of her/her classmates?	ABOVE 5	4	AVERAGE 3	2	BELOW 1	COMMUNICATION	<input type="checkbox"/>
8. How does the student's vocabulary and word usage skills compare with those of other students in his/her age group?	ABOVE 5	4	AVERAGE 3	2	BELOW 1		
9. How proficient is the student at telling a story or relating happenings from home when compared to classmates?	ABOVE 5	4	AVERAGE 3	2	BELOW 1		
10. How often does the student volunteer information to class discussions or in answer to teacher questions?	FREQUENTLY 5	4	OCCASIONALLY 3	2	NEVER 1	CLASS PARTICIPATION	<input type="checkbox"/>
11. With what frequency does the student complete his/her class and homework assignments within the time allocated?	ALWAYS 5	4	USUALLY 3	2	SELDOM 1		
12. After instruction, does the student have difficulty starting to work (looks at other students working or asks for help)?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
13. Does the student demonstrate any behaviors that seem unusual or inappropriate when compared to other students?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1	SCHOOL BEHAVIOR	<input type="checkbox"/>
14. Does the student become frustrated easily, sometimes to the point of losing emotional control?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
15. In general, how would you rank the student's relationship with peers (ability to get along with others)?	GOOD 5	4	AVERAGE 3	2	POOR 1		



TEACHER COMMENTS

Has this child repeated a grade, had frequent absences or experienced health problems (including ear infections and colds)? Has the student received, or is he/she now receiving, special services? Does the child have any other health problems that may be pertinent to his/ her educational functioning?

The S.I.F.T.E.R. is a SCREENING TOOL ONLY

Any student failing this screening in a content area as determined on the scoring grid below should be considered for further assessment, depending on his/her individual needs as per school district criteria. For example, failing in the Academics area suggests an educational assessment, in the Communication area a speech-language assessment, and in the School Behavior area an assessment by a psychologist or a social worker. Failing in the Attention and/or Class Participation area in combination with other areas may suggest an evaluation by an educational audiologist. Children placed in the marginal area are at risk for failing and should be monitored or considered for assessment depending upon additional information.

SCORING

Sum the responses to the three questions in each content area and record in the appropriate box on the reverse side and under Total Score below. Place an **X** on the number that corresponds most closely with the content area score (e.g., if a teacher circled 3, 4 and 2 for the questions in the Academics area, an X would be placed on the number 9 across from the Academics content area). Connect the **X**'s to make a profile.

CONTENT AREA	TOTAL SCORE	PASS						MARGINAL		FAIL				
ACADEMICS		15	14	13	12	11	10	9	8	7	6	5	4	3
ATTENTION		15	14	13	12	11	10	9	8	7	6	5	4	3
COMMUNICATION CLASS		15	14	13	12	11	10	9	8	7	6	5	4	3
PARTICIPATION		15	14	13	12	11	10	9	8	7	6	5	4	3
SOCIAL BEHAVIOR		15	14	13	12	11	10	9	8	7	6	5	4	3