



Today's Date \_\_\_\_\_

*Mailing Address*  
 CAMPUS BOX 7255  
 CHAPEL HILL, NC 27599-7255

Mail or fax completed form to:

Mail: Center for Development and Learning  
 CB# 7255  
 University of North Carolina  
 Chapel Hill, NC 27599-7255  
 Fax: 919-966-2230

Child's Full Name: \_\_\_\_\_ Gender: M F

Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Child Lives With: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Please circle one: birth parent, adoptive parent, stepparent, legal guardian, foster parent

Please circle one: single, married, re-married, separated, divorced, widowed

Legal Custodian(s): \_\_\_\_\_

Primary Contact Person: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_

Cell Phone #: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Secondary Contact Person: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_

Cell Phone #: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Child's School: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Person Completing this Form: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Referred to CDL by (name/relationship): \_\_\_\_\_

Agency/Clinic: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_

What services are you seeking from the CDL for your child? Please be as specific as possible.

1. \_\_\_\_\_
2. \_\_\_\_\_

What are your primary questions/ concerns about your child for a CDL evaluation?

1. \_\_\_\_\_
2. \_\_\_\_\_

Has your child been assessed previously for school performance, learning, behavioral, developmental and/or social-emotional problems?      Yes      No

If yes, where (by whom) and when (date or year of testing)? \_\_\_\_\_

\_\_\_\_\_

Diagnosis and/or IQ? \_\_\_\_\_

\_\_\_\_\_

Does your child receive special education and/or behavioral-emotional support services either in or outside of school?      Yes      No

If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child been seen at UNC Hospitals or any UNC Clinics before?      Yes      No

If yes, please provide his or her UNCH medical record #: \_\_\_\_\_

Do we have permission to contact you about your child participating in a research study? Yes No  
(Please call Ugonna Ukwu at 919-966-4788 if you have any questions about our research study).

**Clinical Evaluations:** At this time our Center offers clinical evaluations that target children whose previous assessments and services have not yet fully enhanced their learning and development. Depending on the child's needs, evaluation services may be provided by individual clinicians, small teams of 2 or 3 clinicians, or a full interdisciplinary team. Our clinical staff will review this form to determine the disciplines to include in your child's evaluation. At the present time we have a lengthy waiting list for evaluations.

**\* We recommend that you keep a copy of this CDL Contact Form for your records.**