

Validation of Assessment Form

Please complete the following sections and return this form to Children's disABILITY Services.

Child's Information

Name		Date of Birth	
------	--	---------------	--

Assessment Validation

The child identified above is assessed with a full scale IQ of _____ or a DQ of _____.

Are there any reservations regarding the validity of the test results?

☐ No

☐ Yes

☐ Can't conclude

Comments:

Clinician Information

Clinician Name			
Professional Designation		Telephone Number	
Clinician's Signature		Date	

Send completed forms to:

Children's disABILITY Services - Family Support Services
c/o SSCY Centre
1155 Notre Dame Ave.
Winnipeg, MB R3G 3G1
Fax 204-948-4788

This form is available in alternate formats upon request
Ce formulaire est offert dans d'autres formats sur demande