

**Dyslexia Foundation of Memphis**

APPLICATION FOR REFERRAL OF TESTING

Full name of child \_\_\_\_\_ Birth Date \_\_\_\_\_

Does your child wear glasses? \_\_\_\_\_ Dominant Hand \_\_\_\_\_ Grade \_\_\_\_\_

School Attended \_\_\_\_\_ School to be attended next year \_\_\_\_\_

\_\_\_\_\_ Has child been retained? \_\_\_\_\_

Is your child on medication? \_\_\_\_\_ If so, what? \_\_\_\_\_

Has child received special help outside classroom? \_\_\_\_\_

Please specify type of help \_\_\_\_\_

Full name of head of household where child resides:

\_\_\_\_\_  
(First) (Middle) (Last)

Mother's name \_\_\_\_\_

Child's address \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_

Has child been tested previously? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

By whom? \_\_\_\_\_ (Test results should be within the past 2 years)

Results \_\_\_\_\_

By whom were you referred to the Foundation? \_\_\_\_\_

Enclose a check for \$50.00 payable to The Dyslexia Foundation of Memphis. This Referral Fee is **NOT REFUNDABLE**. Also, please enclose a copy of your child's last evaluation.

Completed application with check should be mailed to:

*Dyslexia Foundation of Memphis*

Paula Landrum  
4901 Montgomery  
Millington, TN 38053

\_\_\_\_\_  
Signature of Parent or Guardian

Services of The Dyslexia Foundation of Memphis are provided without regard to race, creed, national or ethnic origin.