Report Writing Guide

GENERAL INFORMATION:

1. The majority of the report (except for the psychometric summary) should be readable by almost any literate adult with an average intelligence. This means that it should be on about a 6th grade reading level.
2. The Psychometric Summary section is for professionals to interpret; the body of the report is for all other readers.
3. If you have knowledge that is interesting but potentially embarrassing for the client, do not write it in the report unless it is also diagnostic.
4. If you give an assessment and score it, you must include the information in the report. This counts EVEN IF you don’t agree with the results. If you disagree with the results, write a descriptor of why you do not think that the test results were valid but do not ignore the data that the results provides.
5. Never forget your audience. If you work in a clinic, you want to remember that any report written is for an individual client’s use so it should be tailored to help with that client’s needs. If you work in a school system, you want to remember that they have different needs and information that they require. This holds true for any setting.
6. Finally, a report is like a piece of art. Each artist will interpret it differently. Let your style emerge from a template, but do not be bound to it. By the time you work as a practitioner for several years, your work will reflect your way of presenting materials. This template should be used as a guide only.

HEADER INFORMATION:

1. Clinic or school district complete name
2. If district or clinic cannot be located from the information in the report and title, then address and phone number information is needed as well.
3. The word “Confidential” needs to be on the header.

CLIENT IDENTIFICATION:

1. Name
2. Student Number (if applicable)
3. Age (at the time of testing)
4. Gender
5. Birthday
6. Parent/Guardian name(s)
7. Address
8. School (if applicable)
9. Grade (if applicable)
10. Dates evaluated (all dates should be listed)
11. Date of the final draft of the report
12. Examiner’s name and credentials
13. Translator’s name and credentials (if applicable)
REASON FOR REFERRAL:
1. Report the name of the person, system, or committee who referred the client.
2. Report the general, primary reason for referral.
4. Report any secondary difficulties that are not considered to be the biggest problem.
5. Describe any previous attempts to solve these problems and the success of these attempts.

BACKGROUND INFORMATION:
1. Background information can be described from current informants or previous records.
2. Report how and when the background information was obtained.
3. Report any prenatal, birth, or immediately after delivery information.
4. Report developmental milestone information (crawling, walking, talking, toileting, etc.).
5. Describe any significant history of medical problems and treatment.
6. Describe any current medical problems, treatment, and medications.
7. Report any previous academic or therapeutic interventions (e.g., previous special education services, counseling, psychiatric hospitalization, etc.).
8. Provide a brief description of at least one positive general comment about the client as described by the background informant.

PREVIOUS TEST RESULTS AND VISION AND HEARING SCREENINGS
1. Start chronologically and provide any information on previous psychoeducational assessments.
   a. Include any relevant assessment observations (if test results were described as questionable for any reason).
   b. Include all important assessment result information (e.g., if the current referral is for academic problems, you do not need to repeat previous report information in detail concerning emotional assessment. However, you can write a simple statement describing that it occurred).
   c. Provide diagnostic decisions from the previous reports.
2. Describe any other type of individual evaluations done if known
   a. Speech/language
   b. OT or PT
   c. Psychological evaluation
3. Indicate any previous screening or high-stakes testing data that you know (e.g., ITBS, SAT, high school graduation test, etc.)
4. Provide information on the latest known hearing and vision screening. If you are in a clinic, investigate informally or find out the most recent results. If you are in a school and this is not available, investigate why.
ASSESSMENT MEASURES AND PROCEDURES:

1. List all formal assessments given
   a. Intelligence tests
   b. Intelligence screeners
   c. Achievement tests
   d. Normative rating scales
2. List all informal assessments given
   a. Interviews
   b. Projective tests
   c. Classroom observations
   d. Curriculum-based measures
   e. Portfolio assessments
3. List any contacts or record reviews

TEST BEHAVIOR AND OBSERVATIONS:

1. Describe physical appearance
   a. Groomed?
   b. Clean?
   c. Appears chronological age?
   d. Average height and weight for age?
   e. Anything unusual about her appearance?
2. Manner during testing
   a. Attentive?
   b. Motivated?
   c. Tired?
   d. Wired?
   e. Note if there is a substance abuse concern
3. Rapport description
4. Negative environmental or room factors should be noted
5. Was testing considered to be valid? If not, is it considered to be an overestimate or an underestimate of ability?

ANALYSIS AND INTERPRETATION OF TEST RESULTS:

INTELLECTUAL FUNCTIONING:

1. State which test was given in the opening sentence. Each test should have its own paragraph.
2. Describe composite score. If the composite score is not interpretable for any reason, state that you cannot report it as it is not an accurate measure.
3. Describe cluster or area scores.
4. Describe individual subtest scores only if they are unusual in some way. If you state a subtest score, describe the subtest in some way (NOTE: do not write actual test items here as that is breaking copyright).
5. If there are any strengths or weakness, make sure that you describe those as well.

ACADEMIC FUNCTIONING:

1. State which test was given in the opening sentence. Each test should have its own paragraph.
2. Describe composite score. If the composite score is not interpretable for any reason, state that you cannot report it as it is not an accurate measure.
3. Describe cluster or area scores.
4. Describe individual subtest scores only if they are unusual in some way. If you state a subtest score, describe the subtest in some way (NOTE: do not write actual test items here as that is breaking copyright).
5. If there are any strengths or weakness, make sure that you describe those as well.
6. Describe actual performance on math, reading, and writing. This should be done in terms of what the client was able to demonstrate during the session. This description should be in the positive (e.g., he/she was able to…. NOT he/she couldn’t….). Any difficulties should be described in terms of specific struggles as well.
7. Any academic adaptive techniques should be described as well (e.g., counting on fingers, sounding out unfamiliar words, spelling phonetically, taking additional time, etc.)

ADAPTIVE BEHAVIOR:

1. This section should be included even if there are not suspicions of problems. If nothing was examined b/c no concerns, make a statement reflecting that no testing was conducted in this area as there were not problems noted.
2. Areas of special note in this section are communication skills, self-help skills, daily living skills, social skills (not negative socialization but underdeveloped abilities to play with same-age peers), and abilities to follow classroom rituals and routines.
3. Describe any informal teacher, parent or individual reports of adaptive skills.
4. Describe any formal teacher, parent, or individual assessment data.
5. Include any observational data from the classroom or test setting that is important.

SOCIAL/EMOTIONAL/BEHAVIORAL FUNCTIONING

1. This section should focus only on social/ emotional/ behavioral functioning. All three should be described at some level.
2. This section should be included even if there are not suspicions of problems. If nothing was examined b/c no concerns, make a statement reflecting that no testing was conducted in this area as there were not problems noted.
3. Report teacher, parent, or individual problems in social, emotional, or behavioral problems in general terms (e.g., difficulty completing assignments).
4. Take each general area and describe these in more specific terms (e.g., difficulty staying focused, problems with inattention, acting impulsively, etc.).
5. Describe any informal information obtained
   a. Interview data
   b. Projective testing (if applicable)
   c. Record reviews (if applicable)
6. Report any formal rating scale data and significant scores.

SUMMARY

1. Generally, this should be only one short paragraph for an initial and two short
   paragraphs for a re-evaluation. In a re-evaluation, the first paragraph should focus
   on previous results and the second should focus on current results. Initials should
   only have current result data.
2. The opening sentence should give a short demographic description of the child.
3. Each area of skills should be described in one sentence following this (one
   sentence for cognitive, one sentence for social, emotional, and behavioral, etc.).
   Any important background information should be summed up in one or two
   sentences.

DIAGNOSTIC STATEMENTS (do not add this as a subtitle)

1. For a school report, you may wish to include the following paragraph, “The
   information contained in this report should be considered along with information
   provided by the parent and other school personnel in educational planning.
   Review of xx’s eligibility in the [add qualifying special education program name
   here] program by an Individualized Education Program Team is recommended. “
2. For a clinical report, DSM-IV Axis information should be reported.

RECOMMENDATIONS AND SUGGESTIONS:

1. A recommendation should be made for each referral question. This is true even if
   the client did not qualify for special education or did not receive a DSM-IV
   diagnosis.
2. Recommendations should always be stated positively (e.g., “break long
   assignments into smaller sections” and NOT “don’t give long assignments).
3. Recommendations should be tailored for the referring person. If this is a parent
   referral, then the recommendations should be things to do at home. If this is a
   school referral, then the recommendations should be things teachers can do at
   school.
4. Recommendations should be feasible. Do not ask for teachers and parents to
   spend money or time resources that are not going to be available to them.
5. Recommendations should be based on empirically supported intervention
   strategies.
SIGNATURE LINE: (this header should not be written in)

1. A line should be available to sign.
2. Your complete name and latest degree should be added.
3. Any certification or licensure should be included on a second line.
4. Your title should be added at the bottom.
5. Your should only sign the completed, final draft.

PSYCHOMETRIC SUMMARY

TEST DESCRIPTION:

1. The psychometric summary should start on a new, fresh page.
2. Write one complete descriptor for each scored test administered.
   a. Write title out in words and in its acronym.
   b. Add date administered.
   c. Add person administered.
   d. Add a brief (1-3 sentence description of the test).
   e. Write a brief description of what average scores look like.
   f. Report subtest standard scores or T-scores.
   g. Report domain scores or test composite scores.
      i. Standard Scores or T-scores
      ii. Percentile Ranks
      iii. 90% Confidence Interval
3. An example follows below:

REYNOLDS INTELLECTUAL ASSESSMENT SCALES (RIAS)
Date administered: [date here]
Administered by: [Administrator’s name here]

The RIAS is an individually administered measure of intellectual ability for ages from 3 to 94.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Standard Score</th>
<th>Percentile Rank</th>
<th>90% Confidence Bands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Intelligence Index (VIX)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonverbal Intelligence Index (NIX)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Memory Index (Not Part of CIX)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Intelligence Index (CIX)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

The following T-scores have a mean of 50 and a standard deviation of 10. Scores between 40 and 60 are in the average range.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Verbal Battery</th>
<th>Nonverbal Battery</th>
<th>Memory Battery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guess What</td>
<td>SS</td>
<td>Odd-Item Out</td>
<td>Verbal Memory</td>
</tr>
<tr>
<td>Verbal Reasoning</td>
<td></td>
<td>What’s Missing</td>
<td>Nonverbal Memory</td>
</tr>
</tbody>
</table>

The following composite standard scores have a mean of 100 and a standard deviation of 15. Scores between 85 and 115 are considered average.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Standard Score</th>
<th>Percentile Rank</th>
<th>90% Confidence Bands</th>
</tr>
</thead>
</table>