



REFERRAL FOR AUTISM SUPPORT SERVICES

Revised - JULY 1, 2008

INTERMEDIATE UNIT I
Fayette-Greene-Washington

I. Area(s) of Specific Concerns:

- | | |
|---|--|
| <input type="checkbox"/> Academic program | <input type="checkbox"/> Inclusion |
| <input type="checkbox"/> Behavior issues | <input type="checkbox"/> Environmental |
| <input type="checkbox"/> Social Interaction | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Transition | <input type="checkbox"/> Data Collection |
| <input type="checkbox"/> Sensory issues | <input type="checkbox"/> Other (Specify) |

II. Current Status:

- Pre-referral/Screening
- Initial Referral (Permission to Evaluate)
- Reevaluation (Permission to Reevaluate)
- Transfer Student: _____ School District
- Chapter 15 / SA
- Chapter 16
- Other: (Specify) _____

III. Student Specific Information:

Student: _____ D.O.B. _____ Grade: _____

Parent/Guardian: _____

Mailing Address: _____

Phone (home): _____ (work): _____

MA Eligible: Yes No

MA# _____ PAsecureID _____

School District of Residence: _____

School Attending: _____ School Phone: _____

Contact Person/Role: _____ Phone: _____

Contact Person's Email Address: _____

Teacher's Name: _____ Current Program: _____

Teacher's Email: _____

LEA Signature (Required)

Date

Approved By: _____

Supervisor

Date

Referred To: _____

Support Staff

Date

Student Name: _____

D.O.B: _____

IV. Services Completed

- | | | |
|--------------------------|----------------------------|-------------|
| <input type="checkbox"/> | LEA Consultation | Date: _____ |
| <input type="checkbox"/> | Teacher Consultation | Date: _____ |
| <input type="checkbox"/> | Classroom Observation | Date: _____ |
| <input type="checkbox"/> | ER/IEP Meeting | Date: _____ |
| <input type="checkbox"/> | Interagency/CASSP Meeting | Date: _____ |
| <input type="checkbox"/> | Environmental Adjustments | Date: _____ |
| <input type="checkbox"/> | Sensory Activities | Date: _____ |
| <input type="checkbox"/> | Communication Strategies | Date: _____ |
| <input type="checkbox"/> | Academic Support | Date: _____ |
| <input type="checkbox"/> | Data Collection Techniques | Date: _____ |
| <input type="checkbox"/> | Resource Acquisition | Date: _____ |
| <input type="checkbox"/> | Agency Consultation | Date: _____ |
| <input type="checkbox"/> | Behavior Strategies / Plan | Date: _____ |
| <input type="checkbox"/> | Other: _____ | Date: _____ |
| <input type="checkbox"/> | Other: _____ | Date: _____ |
| <input type="checkbox"/> | Other: _____ | Date: _____ |

FOLLOW-UP NOTES:

Autism Consultant's Signature

Date