

Autism Team Services Referral Form

Student's Name: _____

Age: _____

School: _____

Grade: _____

Teacher/Case Manger: _____

Current Classification: _____

Person Making Referral: _____

Date: _____

Reason for Referral

The IEP team has concerns regarding (*check all that apply*):

Social Concerns:

- Poor eye gaze/contact
- Poor use/understanding of facial expressions
- Poor use/understanding of gestures
- Poor body posture
- Little or no peer interaction
- Little or no spontaneous sharing of enjoyment, interests, or achievements
- Lack of social reciprocity

Communication Concerns:

- Delay or lack of spoken language
(w/no use of compensatory gesture)
- Doesn't initiate or sustain conversation
- Exhibits stereotyped/repetitive language & idiosyncratic language
- Lack of varied, spontaneous pretend play
(relative to age/developmental level)
- Lack of social imitative play
(relative to age/developmental level)

Behavioral Concerns:

- Abnormal preoccupation with items, topics, or ideas
- Inflexible, nonfunctional routines or rituals
- Repetitive motor mannerisms, e.g. hand or finger flapping
- Persistent preoccupation with parts of objects

Comments: _____

Has the parent/guardian given permission for Autism Team involvement? Yes No

Team Members involved in referral decision (there must be at least 3):

Name:

Title/Position:

Name:

Title/Position:

Assessment requested:

Date parent/guardian signed permission to assess:

Location of signed permission to assess:

Consultation requested:

Person to contact

Name: _____

Phone: _____

Best time of day to call: _____

For Office Use Only

Date received: _____ Date contacted: _____ Decision: _____

Assessment Tools & Scores/Results:

ADOS: _____ Vineland: _____ ASDS: _____ CARS: _____

GARS: _____ PEP-R: _____ APEP: _____ Other: _____