Autism Interdisciplinary Team Referral Form

Student Name:_____ Date of referral:_____

District/School:_____ DOB: _____Grade:_____

School Contact:_____ phone:_____ email:_____

Parent/Caregiver Name(s):_____ Phone(s):_____

1. Students with current IEP – check all that apply

- ❑ Consultation :

__behavior __ communication __academic programming __community resources

__transition __sensory/motor __daily living skills __social

__attention __other:_____

- ❑ Assessment:__screening __reevaluation __clinical diagnosis
- ❑ Training:__staff __caregiver(s)

2. Documentation Required:

__referral form

__Copy of current IEP

__copy of most recent evaluation or reevaluation

1. Students without IEP

- ❑ MTSS/SIT consultation
- ❑ Assessment: __screening __ initial evaluation

2. Documentation Required:

__referral form

__copy of MTSS/SIT paperwork

3. CHECK ALL AREAS OF CONCERN:

Social Concerns:

- ❑ Poor eye gaze/contact
- ❑ Poor use/understanding of facial expressions
- ❑ Poor use/understanding of gestures
- ❑ 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 (with 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
- ❑ Aggressive behavior (describe below)

4. Comments:_____

_____

_____

_____ (complete reverse side)

5. Describe interventions/strategies already implemented related to the areas of concern:_____

_____

_____

_____

_____

6. What end result do you hope to achieve after completing this referral and involving the Autism Interdisciplinary Team (AIT)?_____

_____

_____

_____

7. School team members involved in the referral decision (must be at least 3 and include school psychologist):

Name:	Title/position	Name:	Title/position
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Autism Interdisciplinary Team Contract

The district agrees to:

1. Commit school team members who are currently working with the student to meet on a regular basis with each other and with the AIT.
2. Demonstrate a good faith effort in implementing action plans developed by school team and AIT.
3. Record data and maintain documentation of action plan implementation to determine effectiveness of recommended interventions.
4. Actively communicate with member(s) of AIT regarding progress/areas of concern with the implementation of the action plan.

The mission of the AIT is to increase autonomy of the school teams to successfully maximize educational outcomes for all students with autism.

Exit Process

The AIT's involvement will gradually decrease as the targeted action plan is developed and subsequent program development/modifications are identified. Data collection to document the student's progress toward critical skill development is an expectation of the school team. If the action plan and data collection are not being consistently implemented, the AIT's involvement will be discontinued.

_____ _____

Signature of Parent/Caregiver Date Signature of Building Administrator Date

SEND COMPLETED FORM TO Shara Meyer (Autism Coordinator) at Keystone. Email (smeyer@keystonelearning.org) or call (785-608-8587) if you have questions.