

Referral Form

EIASE Autism Team

Not all children who fall on the autism spectrum will require the services of the Autism Team. The level of involvement will be determined on an individualized basis. Based upon a review of the referral packet, the school team may be given further steps for problem solving or the Autism Team may become involved.

Please attach the following documents to this referral form:

<u>Required: Medical diagnosis of Autism Spectrum Disorder OR special education eligibility of autism</u>		
Current IEP	Outside evaluations if provided	Behavior plan
Most recent EDC	Building Support Team information	Student schedule

Person Completing Referral: _____ Date of Referral: _____

Student Name: _____ Age and DOB: _____

School: _____ Grade/Program: _____

Student's Mode of Communication: _____

Medications: _____

Reason for Referral

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

<u>Social Concerns:</u>	<u>Communication Concerns:</u>	<u>Behavioral Concerns:</u>
<input type="checkbox"/> Poor eye gaze/contact	<input type="checkbox"/> Delay or lack of spoken language (w/no use of compensatory gesture)	<input type="checkbox"/> Abnormal preoccupation with items, topics, or ideas
<input type="checkbox"/> Poor use/understanding of facial expressions	<input type="checkbox"/> Doesn't initiate or sustain conversation	<input type="checkbox"/> Inflexible, nonfunctional routines or rituals
<input type="checkbox"/> Poor use/understanding of gestures	<input type="checkbox"/> Exhibits stereotyped/repetitive language & idiosyncratic language	<input type="checkbox"/> Repetitive motor mannerisms, e.g. hand or finger flapping
<input type="checkbox"/> Poor body posture	<input type="checkbox"/> Lack of varied, spontaneous pretend play (relative to age/developmental level)	<input type="checkbox"/> Persistent preoccupation with parts of objects
<input type="checkbox"/> Little or no peer interaction	<input type="checkbox"/> Lack of social imitative play (relative to age/developmental level)	<input type="checkbox"/> Aggressive behavior
<input type="checkbox"/> Little or no spontaneous sharing of enjoyment, interests, or achievements		
<input type="checkbox"/> Lack of social reciprocity		

Comments: _____

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

What end result do you hope to achieve after completing this referral and involving the Autism Team? _____

List any pertinent information the team needs to know about this case (e.g. due process, need for increased parent involvement, etc): _____

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

Name:	Title/Position:	Name:	Title/Position:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Autism 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 EIASE Autism Team.
- 2.** Demonstrate a good faith effort in implementing action plans developed by school team and EIASE Autism Teams.
- 3.** Record data and maintain documentation of action plan implementation to determine effectiveness of recommended interventions.
- 4.** Actively communicate with member(s) of the Autism Team regarding progress/areas of concern with the implementation of the action plan.

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

Exit Process

The Autism Team'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 Autism Team's involvement will be discontinued.

Building Administrator's Signature

Date