Referral to ESU 16 Autism Team

Referral Date: _____ Person/Agency Making the Referral: _____

Student/Family Information

Student's Name: _____ D.O.B: _____ Age: _____

Grade: _____ Gender: _____ Hours/Days Student Attends School: _____

Parent/Guardian Name: _____ Telephone #: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____

Primary Language of Family (used most consistently in the home): _____

District Information

School Name: _____ District: _____

School Contact Person: _____ Contact Person's Email:_____

Position/Title_____ Telephone #: _____

Classroom Teacher: _____

Verification/Diagnosis Information

Does the student have an **educational verification** of Autism per Rule 51? _____

Date of Autism Verification: _____ Other Verification: _____ Date: _____

Does the student have a **medical diagnosis** of Autism? _____ List agency or person who made the diagnosis: (Physician, Neurologist, Psychiatrist, Munroe-Meyer, etc): _____

Services the Student Currently Receives

_____ Resource _____ Speech/Language _____ Paraeducator Support

Other: (PT/OT, Counseling, Social Skills Training, etc.) _____

If additional related services are checked above please get input from the related service providers regarding their observations, and any strategies tried both successful and unsuccessful (PLEASE ATTACH).

Current IEP Program and Areas of Concern

Name of Student: _____ Student's Date of Birth: _____

1. What do resource services currently look like?

2. Strategies currently using: _____ Structured TEACCH _____ Task Boxes _____ Visual supports (be specific)

3. Describe any strategies used in the past and why they were stopped.

4. Describe the student's on-task behavior compared to peers.

5. Describe how student follows written and oral directions.

6. Describe how the student behaves during learning opportunities with minimal structure (i.e. non-instructional times and transitions such as assemblies, hallway transitions, restroom breaks, library, etc).

7. Describe how the student works independently.

8. Describe how the student is doing with classroom work.

9. Describe the student's social interactions with other children (playground, classroom, lunchroom, P.E., music).

10. What would you most like to gain from the Autism Team coming in?

Nebraska ASD Network Technical Assistance Request Form

Date of Request: _____ School District: _____

Primary Contact: _____ Phone: _____ Email: _____

Name of Student: _____ Student's Date of Birth: _____

Which Level of TA are you requesting?	**Please identify 1-3 areas of focus for the consult.**

❑ **Level 1:** Consultation from 1-2 team members around a specific programming concern.
 	
❑ **Level 2:** Review of current IEP and programming, classroom observations, programming recommendation and strategies.
 	
❑ **Level 3:** Full Evaluation, including record review, observations, consultation and ADOS testing.
	❑ Verification/Assessment
	❑ Program Planning
	❑ IEP Development
	❑ Behavior
	❑ Communication
	❑ Social Skills
	❑ Vocational
	❑ Academic/Educational Strategies
	❑ Motor/Sensory/OT/PT
	  ❑ Gross Motor
	  ❑ Fine Motor
	  ❑ Sensory
	
	❑ Specific Strategies: _____
	_____
	_____
	
	❑ Other: _____
	_____
	_____

Desired Outcomes from Autism Team Visit: (please check one)

- ❑ Informal written report listing feedback and strategies to try (Ziggurat Model)
- ❑ Full Formal Report
  - ❑ Meeting with pertinent team members, teachers, paras
  - ❑ Meeting with full team and with parents

Who initiated this referral:

- ❑ MDT Team
- ❑ IEP Team
- ❑ Parent(s)

Team Member Contact Information

Name of Student: _____ Student's Date of Birth: _____

Please provide a list of all team members and email addresses: (including the resource teacher, SLP, OT, PT, general education teacher, administrator, and parents).

Title:	Team Member Name:	Email:

Please indicate the preferred times within the student's schedule for observation/testing (day of the week/ a.m. or p.m./ class periods and times, etc.)	Please indicate the preferred times for the ASD team to meet with the IEP team (same day of observation).
_____	_____
_____	_____
_____	_____

Parent/Guardian Permission for Release of Information:

Name of Student: _____ Student's Date of Birth: _____

I give my permission for information to be exchanged regarding my child,

_____*, the local school district,*
Child's name

_____ *and the ESU 16 Autism Team.*
Local school district

This information may include verbal exchange of information, written reports, and on-site observation and consultation from the ESU 16 Autism Team Member(s).

Parent/Guardian Signature: _____ Date: _____

District Representative Signature: _____ Date: _____

The Nebraska ASD Network's mission is to build the local capacity of school districts and families by offering training and technical assistance related to educational programming for students with autism spectrum disorders. We offer regional libraries and provide support related to educational verification, IEP development and educational program planning.

The Nebraska ASD Network wishes to express our commitment to working with your school team. We acknowledge the complexity of providing quality services to your school and the time commitment involved. Your signature below represents acknowledgement of the time commitment required by your school and/or district team to receive this support and an agreement to commit to the technical assistance plan that is developed by the team with the assistance of the ASD network.

_____ _____

Direct Administrator Signature Date