Stark County Educational Service Center
Autism Consultation
District Referral Form for Individual Autism Support Services

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This referral form is to be completed prior to the initial meeting with the Autism Consultant. The referring professional will need to obtain the signature of the student's district of residence's Special Education Director before forwarding it to the Autism Consultant. Completed referral forms can be mailed or faxed to: Cis Schumacher, SCESC, 2100 38th ST. NW, Canton, Ohio 44709: Fax: 330.493.1887. If you have further need of assistance, please contact Cis Schumacher, at 330.492.8136 Ext.1451 or email: cis.schumacher@email.sparcc.org

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Student Name: ______________________________________ DOB__________ Sex: ___M ____F

Grade/Placement: _______________________ School: ______________________ Phone: ___________________

Autism Diagnosis: ____

Other Disabilities: ____N ___Y if yes please state: ____

Current support services: Please Circle: S/L OT PT Personal Aid

District of Residence: __________________________________ District of Attendance: _______________________

Teacher(s)____ Email: __________________________________

Parent(s) Name: ____ ___________________________________

Parent(s) Address: ____

Parent's Phone: __________________ Have parent(s) been contacted regarding this referral? __Y __N

Parent Permission for Review was signed _____Y _____N Form is available online at ESC website if needed:

Please check the following services(s) you are requesting:

___Do a single observation and follow up with: (team contact person): ___________________________
Phone: ________________________________ Email: ____
___ Do several observations and work with staff on developing a plan and strategies related to the Student's areas of concern.
___ Complete a Functional Behavior Assessment (FBA) and make recommendations.
___ Other: Please explain: ____
____

Please attach the following documents:

___Most recent ETR
___Most recent IEP
___Signed parent permission to observe/consult and review records. * Must have before first observation and/or consult.

Area(s) of concern: ☐ **Behavior** ☐ **Communication** ☐ **Socialization** ☐ **Academic Performance**

Statement of the Problem (Why are you making the referral?) ____
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____

What strategies, methodologies, and interventions have you already tried? (Please be specific, e.g. pictures, visual schedule, social interventions, PECS, communication system/devices, visual timer, reduced workload).
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What strategies/ methodologies and/or interventions have you found to be most helpful when working with this student?
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What educational/vocational programming is in place for this student and/or related services are currently provided? (List type & amount):
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Are there significant factors about the student's strengths, learning style, coping strategies, or interests that the team should consider?
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What is the most important outcome that you would like for this student to achieve? ____________________
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Contact Information:
The Autism Consultant will contact the referring staff member for a team meeting when this form is received at the SCESC. **Please note that it is the responsibility of the District contact person to invite all team members to any scheduled meetings that are a result of this request. Team members should include all service providers and the parent(s) if appropriate**.

Referring Staff Member: ____School________________________

Phone# & email: ______________________________ Email: ____________________________________

If you prefer to be contacted by phone, when is the best time to reach you? ____________________________

____ Date: ___________________________
Signature of Referring Staff Person/ Date

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*** Signature of Special Education Director/Date**

Office Use:
Date Returned_____________________________1st visit scheduled_________________________________

Comments: Sept./2012 ASD