



For office use:
Date of Init. Mtg. _____

CHESTER COUNTY INTERMEDIATE UNIT
Student Services Division

Autism Support Team
Referral Information Form

Student _____ Date of Birth _____
 School _____ Age _____
 Teacher _____ Grade _____
 District of Residence _____ Referral Date _____

_____ Referred by _____ Title _____ Phone/e-mail _____

_____ Contact Name _____ Title _____ Phone/e-mail _____
(only if different than "Referred by")

_____ Date of IEP _____ No IEP _____ Chapter 15/SA _____ Other _____

DIAGNOSIS (Please check one)
 Autism _____ Asperger Syndrome _____ PDD NOS _____

CURRENT SERVICES
 _____ Speech/Language _____ PT _____ OT _____ TSS _____ Instr. Ass't
 _____ Special Ed. class/teacher _____ LS, LSS, ES, AS, MDS, EI _____ Vision services

Please check and describe areas of specific concern :

Describe the concern:	Strategies in place that seem to be effective:	Strategies tried that did not seem to be effective:
___ BEHAVIOR		
___ COMMUNICATION		
___ SOCIAL/PEER INTERACTION		
___ SENSORY		

___ OTHER CONCERNS: 		
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List student strengths and interests (include any preferred items or activities that may be useful in planning strategies for this student) <hr/> <hr/> <hr/> <hr/>

Is the student's parent aware of your request for support from the Autism Training and Consultation (TaC) Team? YES NO

Do we have permission to review the IEP? YES NO
If yes please include current copy of IEP with referral.

 Special Ed. Supervisor or Principal signature

 Date

 Referring professional's signature

 Date

<h2 style="margin: 0;">Autism Support Team</h2>
<h3 style="margin: 0;">Chester County Intermediate Unit</h3>
455 Boot Rd Downingtown, PA 19335 Attention: Dr. Jacalyn Auris/Lisa Snyder Phone 484-237-5042 Fax# 484-237-5167