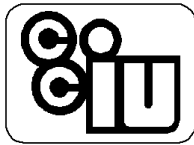


For office use:
Date of Init. Mtg _____



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

 Contact Name Title Phone

(only if different than "Referred by")

Can you be reached by e-mail? Address: _____

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

Does the student have a diagnosis within the Autism Spectrum? Please explain.

Services currently received.

____ Speech/Language ____ PT ____ OT ____ Vision services ____ TSS ____ Instr. Ass't

____ Special Ed. class/teacher ____ LS, LSS, ES, AS, MDS, EI

Please check areas of specific concern:

Observations:	Strategies in place that seem to be effective:	Strategies tried that did not seem to be effective:
____ BEHAVIOR		
____ ACADEMICS		
____ SOCIAL/PEER INTERACTION		

___ TRANSITION		
___ COMMUNICATION		
___ SENSORY		
___ OTHER:		

What does the student do well?	When?
_____	_____
_____	_____
_____	_____
_____	_____

Please list any preferred items, activities that would be useful in planning strategies for this particular student. _____

Is the student's parent aware of your request for support from the Autism Support Team? YES NO
 Do we have permission to review the IEP? YES NO

Principal Signature

Date

Special Ed. Supervisor Signature

Date

Referring professional's signature

Date

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<p>AUTISM SUPPORT TEAM c/o Donna Romanowski Chester County Intermediate Unit 455 Boot Road Downingtown, Pa. 19335 Phone: (484) 237-5190 Fax #: (484) 237-5167</p>
