Marion County Special Education Cooperative
Autism Team Referral
(Autism Screening, Evaluation, and Intervention)

Student Name: _____ **Date of Referral:** _____

School: _____ **DOB:** _____ **Grade:** _____

School Contact: _____ **Phone:** _____ **e-mail:** _____

Parent/Caregiver Name: _____ **Phone(s):** _____

1. Check Area of Need for Student and Staff:

☐ Consultation
- ☐ Behavior ☐ Communication ☐ Academic programming ☐ Community resources
- ☐ Transition ☐ Sensory/motor ☐ Daily living skills ☐ Other:_____

☐ Assessment
- ☐ Screening ☐ Reevaluation ☐ Transition/TTAP

☐ Training
- ☐ School staff ☐ Paraprofessionals ☐ Caregiver(s)

2. Documentation Required – Mark the documentation sent

☐ Referral form ☐ Copy of IEP ☐ Copy of most recent evaluation/reevaluation

☐ General Ed Intervention Plan ☐ Mental Health Reports

3. Check All Areas of Concern

Social Concerns:
- ☐ Poor eye gaze/contact
- ☐ Poor use/understanding of facial expressions
- ☐ Poor use/understanding of gestures
- ☐ Little or no spontaneous sharing of enjoyment, interests or achievements
- ☐ Lack of social reciprocity
- ☐ Hyper or Hypo reactivity to sensory inputs or unusual interest
- ☐ Weak perspective taking

Communication Concerns:
- ☐ Delay or lack of spoken language (with no use of compensatory gestures)
- ☐ Doesn't initiate or sustain conversation
- ☐ Exhibits stereotyped/repetitive language & idiosyncratic language
- ☐ Lack of varied, spontaneous pretend play (relative to age/developmental level)
- ☐ Lack of social imitative play (relative to age/developmental level)

Behavioral Concerns:
- ☐ Abnormal preoccupation with items, topics or ideas
- ☐ Inflexible, nonfunctional routines or rituals
- ☐ Repetitive motor mannerisms (e.g. hand or finger flapping)
- ☐ Persistent preoccupation with parts of objects
- ☐ Aggressive behavior (describe below)

_____
_____
_____

4. Referring Team Members (school staff/parents)

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

_____ _____
Signature of Parent/Caregiver Date

_____ _____
Signature of Building Administrator Date

Send completed form to a member of the Autism Team