

Livingston County Regional Autism Team

CONSULTATION REQUEST FORM

Date of request: _____ Contact person: _____

Name of student: _____ Birthdate: _____

Name of Parent(s)/Guardian(s): _____

School/District: _____ Grade: _____

Entitled for special services at this time? (Circle one) Yes No

If yes, list areas entitled for special services and related services _____

Date of last building team meeting/IEP meeting _____

Reason(s) for this request _____

Prior to this request what interventions have been conducted and what were the results/outcomes? (attach intervention plan(s) and/or other relevant information/medication reports, etc. _____

What behavior is of most concern to the team members? _____

Administrators Signatures:

Building Principal

LCSSU/Program Supervisor

{Return to Dawn Conway, Director, Regional Autism Team Leader}
Date Received @ LCSSU: _____