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 ______________

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Date of <u>last</u> building team meeting/IEP meeting ______________________________

Reason(s) for this request ____

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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. ____

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

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Administrators Signatures:

___________________________ Building Principal

___________________________ LCSSU/Program Supervisor