UW AUTISM CENTER
UNIVERSITY *of* WASHINGTON

Today's Date: ___________________

STUDENT CONSULTATION REQUEST

Name of Agency: ____

Billing Contact Person: ____

Billing Address: ____

Role: ____________________________ Email: ___________________________________

Phone: ___________________________ Fax: ____________________________________

Consultation Contact Person: ____

Role: ____________________________ Email: ___________________________________

Phone: ___________________________ Fax: ____________________________________

STUDENT INFORMATION

Student Initials: ____ Grade: _____________________

Classroom Setting(s) (e.g., self-contained classroom, resource, inclusion):

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Name of School: ____

School Address: ____

City, ST, Zip: _________________________ County: __________________________________

Phone: ____________________________ Fax: ______________________________________

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CONSULTATION INFORMATION

Preferred consultation date(s): ____

School start time: _________________ School end time: _______________

Please identify the specific areas of concern about which you would like to receive support.

___ Communication	___ Social Skills	___ IEE
___ Modifications/Accommodations	___ Behavior Supports	___ FBA
___ Environmental Arrangement	___ Motivational Systems	___ IEP Development
___ Data Collection/Progress Monitor	___ AAC	___ Other: _________

Has the student ever been diagnosed with autism spectrum disorder?

What are the goals of the consultation? What are the specific questions you looking to answer?

TEAM INFORMATION (please list team members associated with student's educational plan)

Role	Name	Email Address	Phone
Parent/Guardian			
Special Education Teacher			
Educational Assistant			
General Education Teacher			
Director of Special Education			
Principal			
SLP			
OT/PT			
Other:			

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PLEASE FAX, EMAIL OR MAIL COMPLETED FORM TO:

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