Today's Date: ________________

CLINICAL CONSULTATION REQUEST

I. AGENCY INFORMATION

Name of Agency: ____

Billing Contact Person: ______________________________________

Billing Address: ____

Role: ____________________ Email: ________________________

Phone: ___________________ Fax: __________________________

Consultation Contact Person: __________________________________

Role: ____________________ Email: ________________________

Phone: ___________________ Fax: __________________________

II. CONSULTATION INFORMATION

Preferred consultation date(s): ________________________________

Preferred start time: ______________ Preferred end time: ______________

Preferred modality: ☐ In-Person Consultation ☐ Virtual Consultation ☐ Either

Address (if in-person): ______________________________
Building Name, Street Address

City, ST, Zip: ________________, _____, ________ County: ________________

Please identify the specific areas on which you would like to receive support.

___ Neurodiversity-Affirming Differential Diagnosis

___ Neurodiversity-Informed Intervention

___ Neurodiversity-Informed Parent Coaching

___ Neurodiversity-Informed Teaching

___ Report Writing

___ Strengths-Based Assessment

___ Other: ____

What are the goals of the consultation? What are specific outcomes you would like from the consultation?

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PLEASE FAX, EMAIL OR MAIL COMPLETED FORM TO:

Training and Consultation Services Team
University of Washington Autism Center
Box 357920 Seattle, WA 98195-7920

Phone: 1-877-408-UWAC (8922) Fax: 1-877-719-8701 Email: uwactrain@uw.edu

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