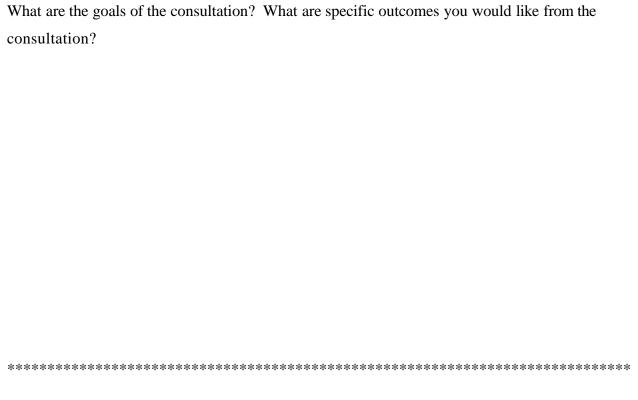


Today's Date:

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 Consulta	ation Virtual Consultation	☐ Either
Address (if in-person):Building Name, Street Address		
City, ST, Zip:	,, County:	
Please identify the specific areas on which Neurodiversity-Affirming Difference Neurodiversity-Informed Intervence Neurodiversity-Informed Parent Compared Par	ntial Diagnosis tion Coaching	
Other:		



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: <u>uwactrain@uw.edu</u>

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