Autism Review Team

Packet Checklist

Child's name: _____ DOB: ____ / ____ / ____

Primary Care Provider: _____Clinic: _____

School District:_____

Packet Forms:

☐ Authorization form release of records

☐ Demographics form

☐ 3 autism tools, filled out by:

       ☐ Parent

       ☐ Gen Ed teacher

       ☐ Special Ed teacher

       ☐ Speech and language pathologist

       ☐ Occupational Therapist / Physical Therapist

       ☐ School Psychologist

       ☐ Daycare provider

Additional Information:

       ☐ Copies of 504 plans or IEPs

       ☐ Reports of any testing done by school psychologists, occupational, language, or physical therapists, including any developmental screenings.

       ☐ Report cards (past 2 years)

       ☐ Well-check or behavioral-visit records from doctors