

AMARILLO INDEPENDENT SCHOOL DISTRICT
Special Education
Amarillo, Texas

Autism Evaluation Team Request

Name of Student: _____ Date of Request: _____
Campus: _____ Date of Birth: _____
Teacher: _____ Age: _____ Grade: _____
Parent Name: _____ Phone: _____
Address: _____ Zip: _____

Is the student currently receiving services as a student with a disability? ___Yes ___ No

If yes, please indicate disability(ies): _____

FIE Date: _____ ARD Date: _____

If no, date of initial referral: _____

Areas of Concern:

Please describe concerns in the following areas:

Communication:

Social/Interpersonal:

Areas/objects of high or intense interest:

Self-injurious/sterotypical/behaviors:

Functional/Self help:

Comments:

Person Notifying Parent

Date of Notification

Evaluation Due By:
(As per ARD)

Notice and Consent must accompany this request. Indicate Autism Evaluation on page 2 of Notice and Consent Form. Please send this completed form to : LSSP at CRC.

*Please also send a copy of student's most recent FIE, summary report (if applicable) and any other reports that might be helpful (psychological, physician, etc.) Thank you.