

# COOPERATIVE ASSOCIATION for SPECIAL EDUCATION

Itinerant Services Office  
1104 N. Main Street  
Lombard, IL 60148-1362

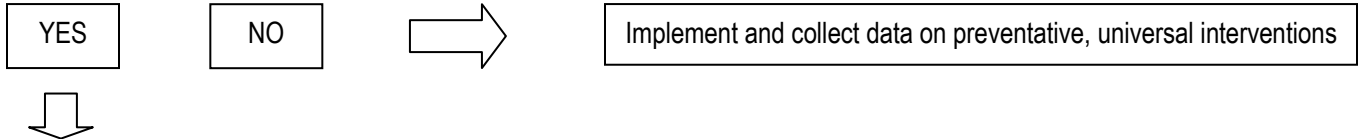
Voice or TTY (630) 629-2600  
FAX (630) 629-2601

Jim Nelson  
Executive Director

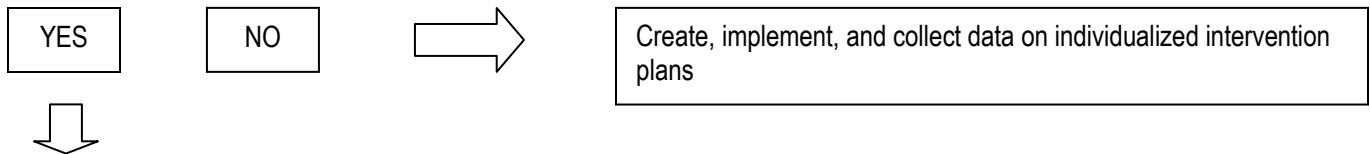
## C.A.S.E. Autism/Behavior Consultant Referral Process

Please use as a guideline when considering a referral for the autism/behavior consultant.

1. Has the student been discussed at the classroom team/universal team level?
  - Classroom and/or special education teacher, related service staff, specials teachers, etc.



2. Has the student been discussed at SST or secondary level?

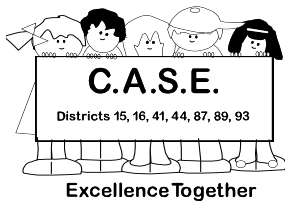


3. Team members complete consultation request form for Autism, Behavioral, Classroom, and/or Transition Planning support and send to **district administrator** for approval.
  - ❖ Please complete all fields to both pages of request form, including student's schedule and preferred observation and meeting days and times
  - ❖ Please attach data from current behavior and/or support plans
  - ❖ Parents need to be notified of the request for consultation by the team

## C.A.S.E. Autism/Behavior Consultant Observation Process

1. Upon receipt of completed form, Autism/Behavior Consultant will schedule times for observation and team meetings.
2. A written support plan and/or report will be generated for the team to implement. This will be routed to all team members following the observation and meeting.
3. The team will implement the strategies discussed for a minimum of two weeks and/or 10 school days.
4. The Autism/Behavior Consultant will complete a post observation and meet with the teacher/team to review data collected and status of the implementation of the support plan strategies.
5. Additional follow up support will be provided as needed.

**It is the mission of CASE to collaborate as educational advocates for children with special needs in order to provide appropriate and high quality educational programs and services.**



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Revised 10/1/10

- AUTISM CONSULTATION REQUEST  
 CLASSROOM / PROGRAM CONSULTATION REQUEST

- BEHAVIOR CONSULTATION REQUEST  
 TRANSITION PLANNING REQUEST

Student:	Teacher:	District:
School:	Program:	Grade:
<input type="checkbox"/> Previous Consultation Provided <input type="checkbox"/> Parent has been contacted (for student request)  Does the student have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No Disability: _____  Does this student have any medical concerns? _____  Is this student taking medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Person: Name: _____ Phone: _____  Email: _____	
	Current Services and Staff Names: <input type="checkbox"/> Resource _____ <input type="checkbox"/> OT _____ <input type="checkbox"/> SW _____	<input type="checkbox"/> SLP _____ <input type="checkbox"/> Psych _____ <input type="checkbox"/> APE _____ <input type="checkbox"/> PT _____

Must Attach Data: <input type="checkbox"/> Classroom (Behavior Chart, Point Sheets, etc.) <input type="checkbox"/> SST <input type="checkbox"/> Tier 1/Universal Interventions <input type="checkbox"/> Tier 2/Secondary Interventions		
Operational Definition of Target Behavior: <input type="checkbox"/> Instructional Level <input type="checkbox"/> Peer Interactions <input type="checkbox"/> Physically hurting others <input type="checkbox"/> Verbal Resistance / Refusal <input type="checkbox"/> Adult Interactions <input type="checkbox"/> Withdrawn socially <input type="checkbox"/> Physical Resistance / Refusal <input type="checkbox"/> Work Completion <input type="checkbox"/> Withdrawn instructionally <input type="checkbox"/> Verbal Communication (Social/Interactions) <input type="checkbox"/> Sensory <input type="checkbox"/> Organization (Materials) <input type="checkbox"/> Limited Communication (Nonverbal/Functional) <input type="checkbox"/> Physically hurting self <input type="checkbox"/> Other _____		
Positive Supports for Target Behavior: <input type="checkbox"/> Behavior Chart / Point Sheet <input type="checkbox"/> Visuals (schedules, communication) <input type="checkbox"/> Time Out <input type="checkbox"/> Classroom Reinforcement Plan <input type="checkbox"/> Social Stories <input type="checkbox"/> Detention <input type="checkbox"/> Individual Reinforcement Plan <input type="checkbox"/> Communication System (PECS, visuals, augmentative) <input type="checkbox"/> Suspension <input type="checkbox"/> FBA/BIP <input type="checkbox"/> Sensory Diet <input type="checkbox"/> Other _____ <input type="checkbox"/> Calming Strategies		
Additional Comments/Information:		

The following signature is required before this request can be processed:

District Representative/Coordinator: \_\_\_\_\_

Please email, mail, or fax to the attention of Tammy Prentiss, [tprentiss@casedupage.com](mailto:tprentiss@casedupage.com) at (630)942-5601, CASE 22W600 Butterfield Rd. Glen Ellyn, IL 60137.

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