FRESNO COUNTY SELPA
SPECIAL EDUCATION LOCAL PLAN AREA

Trina Frazier, Assistant Superintendent

INTERVENTION SUPPORT REFERRAL: AUTISM

Please email to: interventionsupport@fcoe.org

Please Submit the Following:

- ☐ **Current IFSP or IEP**
  - ☐ **Signed Assessment Plan (if assessment in process)**
    Please do not put "Autism Specialist" on Assessment Plan; person responsible is the school psychologist
- ☐ **Current Assessment Reports**
- ☐ **Behavior Intervention Plan, including FBA (if applicable)**

Please describe the support you are seeking, and description of student concerns:

Date: _____

Child's Name: _____ DOB: _____ Age: _____ Gender: _____

District of Residence: _____ School of Attendance: _____ Grade: _____

Parents/Legal Guardian: _____ Address: _____

Foster Parent/LCI (if applicable): _____ Address: _____

Primary Language of Parents: _____ Primary Language of Child: _____

Phone: _____

Best Day(s) and/or Times to Schedule Observation: _____

Referral Contact Person: _____ Title: _____

Phone: _____ Email Address: _____

Special Ed. Teacher/Case Mgr.: _____ Room #: _____ Phone: _____ Email: _____

General Ed. Teacher: _____ Room #: _____ Phone: _____ Email: _____

School Psychologist: _____ Phone: _____ Email: _____

District/LEA referral authorization

Signature: _____ **Date:** _____

Print Name: _____ **Email:** _____

Infant-36 Months:

Eligibility Category: ☐ Developmental Delay ☐ Established Risk ☐ High Risk
Other: ☐ Failed M-CHAT ☐ Medical Diagnosis of Autism ☐ Parent Concern

Age 3-22:

Special Education Eligibility: _____ _____

Please describe previous interventions, including school based counseling, behavior supports, psychological, or guidance services provided to address student's needs (indicating provider, type of services, frequency, and duration):

Other Agencies/Services Involved:

☐ ABA Provider/Home Program
☐ CVRC
☐ Early Head Start
☐ Help Me Grow
☐ All 4 Youth
☐ Department of Behavioral Health
☐ EPU
☐ Public Health
☐ CCS
☐ Department of Social Services
☐ Foster Placement
☐ Turning Point

☐ Other Mental Health Services: _____

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PARENT CONSENT FOR INTERVENTION SUPPORT OBSERVATION & CONSULTATION

To the Parent(s)/Guardian(s) of:

Student:_____ DOB:_____

Address:_____ Home Phone: _____

School:_____ District: _____

While counseling and behavioral strategies are available by school district staff, additional support may be required to meet your child's educational needs. Therefore, we are requesting your permission to refer your child to the Fresno County Superintendent of Schools (FCSS) Intervention Support team for observation and consultation to obtain information to assist the IEP team in developing an appropriate educational program for your child.

☐ I give permission for this referral for FCSS Intervention Support team observation and consultation. The team may observe my child in his/her educational setting and/or other environments, consult with staff, as deemed necessary to assist in IEP team development. This may also include interviewing the student, interviewing staff, reviewing records, collecting baseline data and the like.

☐ I **do not** give my permission for the referral.

_____ _____

Parent Signature Date

1111 Van Ness Avenue • The Towers, Suite 8 • Fresno, California 93721-2000
(559) 497-3779 • TDD (559) 497-3912 • Web Site: www.fcoe.org • FAX: (559) 265-3076

Parent/Guardian Authorization for Release and Exchange of Information

PUPIL/PATIENT INFORMATION: **Date**:_____

Name:_____ **DOB:** _____
Last First M.

I authorize the following individual(s) or organization(s) to release and exchange the above-named individual's medical/educational information as described below (check as needed):

- ☒ _____School District
- ☐ CDE Diagnostic Center for Neurologically Handicapped Children
- ☐ California-Hawaii Elk's Major Project
- ☒ Central Valley Regional Center (CVRC)
- ☐ Community Regional Medical Center
- ☐ Department of Rehabilitation
- ☐ Exceptional Parents Unlimited (EPU)
- ☐ Fresno County Department of Social Services
- ☐ _____Adult Day Program
- ☐ Fresno County Economic Opportunities Commission-Head Start
- ☒ Fresno County Health Department/Human Services System (California Children's Services/MTU, Public Health Nursing, Children's Mental Health Services)
- ☒ Fresno County Superintendent of Schools
- ☐ Fresno County Probation Department
- ☐ United Cerebral Palsy
- ☐ _____ Hospital/Medical Center
- ☒ Valley Children's Healthcare _____ Dept(s)
- ☒ Physician/Clinic/Other: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED AND EXCHANGED (CHECK AS NEEDED):

- ☐ Immunization Record
- ☐ Physician Orders
- ☒ History and Physical
- ☒ Consultation Reports
- ☐ Operative Reports
- ☐ Lab Results/X-ray Reports
- ☐ Discharge Summary
- ☒ Educational Record
- ☐ Ambulatory Clinic Summary
- ☒ Appointment Dates/Times
- ☒ Mental Health Records
- ☒ Other: _____

I request that the information released and exchanged pursuant to this authorization be used for the following purposes only:

- ☒ Educational Assessment
- ☒ Educational Planning
- ☒ Health Care Planning
- ☐ Other:_____

To revoke any authorization granted herein, please send written notification to:

Parent/Guardian Authorization for Release and Exchange of Information

PUPIL/PATIENT INFORMATION: **Date**:_____

Name:_____ **DOB**: _____
Last First M.

DURATION:
This authorization shall become effective immediately and shall remain effective until _____(date) or for one year from the date of signature if no date is entered.

REVOCATION:
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the individual(s) and organization(s) identified in the box on Page 1 of this form. Written revocation will be effective upon receipt, but will not apply to information that has already been disclosed in response to this authorization.

REDISCLOSURE:
I understand that protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it may no longer be protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released and exchanged to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

HEALTH INFORMATION:
I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment.

You may inspect or copy the information to be disclosed, as provided in CFR 164.524.

If a Personal Representative executes this form, that Representative warrants that he or she has authorization to sign this form on the basis of his or her legal relationship to the above referenced pupil. The Personal Representative executing this form warrants that his or her legal relationship to the above referenced pupil is:_____

Witness:_____

_____ _____
Parent/Guardian/Surrogate/Adult Student Date

_____
Print Name (Parent/Guardian/Surrogate/Adult Student)

A copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.