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

☐ Attached with Referral ☐ Following County Operated Referral

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 Fresno County SELPA 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 Fresno County SELPA 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