Lewis County Autism Coalition
Working Together in SW Washington

School Medical Autism Review Team

Packet Checklist

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

Primary Care Provider: _____ Clinic: _____

School District: _____

Packet Forms:

☐ Authorization form release of records

☐ Demographics form

☐ Smart Tools, filled out by:

- ☐ Parent
- ☐ Gen Ed teacher
- ☐ Special Ed teacher
- ☐ Speech and language pathologist
- ☐ Occupational Therapist / Physical Therapist
- ☐ School Psychologist
- ☐ Daycare provider
- ☐ Other: _____

Additional Information:

- ☐ Report cards (past 2 years)
- ☐ Reports of any testing done by school psychologists, occupational, language, or physical therapists including any developmental screenings
- ☐ Copies of 504 plans or IEP's
- ☐ Reports of previous evaluations by physicians, psychologists, or psychiatrists