School Medical Autism Review Team (SMART)  
Final Report

TO: Special Education Director/Building Administrator  
District:  
RE: SMART Team Final Report  
Date:  

Name:______________________________ Birthdate:____________________

The above named student has been reviewed by the medical staff from the School Medical Autism Review Team (SMART) and has resulted in the following conclusions:

____ The student has been evaluated and it has been concluded that he/she **meets the diagnostic criteria for autism.**

____ The student has been evaluated and it has been concluded that he/she **does not meet the diagnostic criteria for Autism.**

____ Other:

If you have any questions or concerns please contact the School Medical Autism Team Coordinator at 360-736-6778 or fax questions to 360-736-6552.