



150 Glenwood Lane • Birmingham, AL 35242-5700 • Phone:(205) 969-2880 • FAX:(205) 967-1323 • www.glenwood.org

Dear Colleague,

Thank you for your interest in receiving services from Glenwood's Consultation and Training team. Our team provides several services including diagnostic assessment for children who may have Autism or another Pervasive Developmental Disorder. Additionally, we provide consultation focused on classroom suggestions and teaching strategies for a specific child in your classroom. **We also now offer transition services to school systems.**

In conjunction with our emphasis on children with Autism and other Pervasive Developmental Disorders, Glenwood employs several specialists who are able to provide school systems or classroom teachers' assistance with or assessment for children with other psychological concerns (e.g., Bipolar, Depression, anxiety, psychosis).

If you are requesting a diagnostic evaluation or specific behavioral intervention, or **transition services**, we ask that you plan for us to see **one child per visit**. Because of the breadth and intensity of completing an effective diagnostic evaluation, it is not feasible to evaluate more than one child per visit.

We ask that you complete all of the necessary information (listed below) prior to sending in the packet of information. You are welcome to keep a clean copy of this referral packet for future use. Should you have questions about completion of the packet, please contact Ms. Angelia Reed at 205-212-6726 for clarifications and questions.

If a student receives a diagnostic evaluation and found eligible to receive services and the school wants additional follow-up services in the form of a classroom suggestion:

1. You **do not** have to complete a new referral if you are requesting a follow-up service within the **same school year**. (Contact Angelia Reed at number listed above)
2. If you are requesting follow-up evaluation for a **new school year**. You must complete a new referral.

To schedule your appointment, we will need the following information:

- Consult Information Form
- History and Current Placement Form
- Current IEP
- Current IQ evaluation
- Speech language evaluation with Expressive Language Equivalent
- Other relevant school evaluations
- Evaluation by other agencies/doctors
- Teacher Questionnaire
- Directions to your school

Send the complete packet to:

**Glenwood, Inc. Community Educational Services
Attention: Administrative Assistant for Community Educational Programs (CEP)
150 Glenwood Lane
Birmingham, Alabama 35242
Phone (205) 212-6726/ fax (205) 212-6739**

Janice Hanson, MA, LPC.

Felicia Houston, Ph.D.

Janice Hanson, M.A., L.P.C.
Division Director, Children's Resource Center

Felicia Houston, Ph.D., Licensed Psychologist
Associate Director of School Based Services

Consultation Referral Form rev. 12/09

(This Form Must Be Included)

Demographic Information

Student: _____ Current Grade: _____

DOB: _____ Gender: _____ Ethnicity: _____

Student resides with (e.g., mother, father, grandparents, etc) _____

Name of Individual (s) Child resides with: _____

Home Address: _____

City/State/Zip: _____

Resident County: _____

Home Phone Number: _____

Work Phone Number: _____

Cell phone Number: _____

Person Making Referral: _____ Phone: _____

Main Contact Person (if different from person making referral): _____

Contact Person Phone Number _____

Name of School Child Attends: _____

School Phone Number: _____

School Physical Street Address: _____

School Mailing Address (If different from above): _____

City/State/Zip: _____

Name of School System: _____

For Office Use Only

Date Received: _____

Client Number: _____

Has individual been seen at Glenwood before Yes No

Individual who confirmed consult: _____

Contact number of individual: _____

Date individual confirmed consult: _____

Current Placement and Educational Services (rev. 12/09) - Please complete in full

Has this child ever been seen by Glenwood staff? Yes _____ No _____

Has this child received any other Glenwood services (past or present)?

_____ Family Support (e.g., in home services)

_____ Respite

_____ Waiting list for Residential or Allan Cott School

_____ Autism Clinic

_____ Consultation and Training: _____ Diagnostic Assessment _____ Classroom Suggestions _____ Super

_____ Other: _____

Type of Classroom child is presently served in (i.e., self contained, regular, resource, MR, ED, Autism, MH, etc.): _____

Student's Teacher Information:

Teacher(s): Name: _____ Position: _____

Teacher(s): Name: _____ Position: _____

Teacher(s): Name: _____ Position: _____

Teacher(s): Name: _____ Position: _____

Primary exceptionality/diagnosis: _____

Under what special education exceptionality is child served? _____

Who Diagnosed: _____ When: _____

Are copies of the diagnostic report attached with this packet? _____ Yes _____ No

What services is the child receiving related to his or her exceptionality? Please check all that apply:

_____ Speech-Language Therapy

_____ Physical Therapy

_____ OT

_____ Social Work

_____ Resource

_____ School Nurse Services

_____ Adaptive PE

_____ Psychological Services

_____ Counseling

Other: _____

Previous Diagnoses (please check all that apply):

- Developmental Delay
- Autism
- Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)
- Asperger's Disorder
- Receptive or Expressive Language Disorder
- Mixed Receptive/Expressive Language Disorder
- Mental Retardation
- Learning Disorder
- Attention-Deficit Hyperactivity Disorder (ADHD)
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder
- Seizure Disorders
- Bi-polar Disorder
- Schizophrenia
- Anxiety
- Depression
- Other: _____

Please provide information regarding other evaluations. *Please attach copies of these evaluations or arrange to have copies mailed to us.*

<input type="checkbox"/> School evaluation	Who? _____	Date: _____
<input type="checkbox"/> Speech/Hearing	Who? _____	Date: _____
<input type="checkbox"/> Neurological	Who? _____	Date: _____
<input type="checkbox"/> Psychiatric	Who? _____	Date: _____
<input type="checkbox"/> Psychologist	Who? _____	Date: _____
<input type="checkbox"/> Occupational Therapist	Who? _____	Date: _____
<input type="checkbox"/> Physical Therapist	Who? _____	Date: _____
<input type="checkbox"/> Developmental	Who? _____	Date: _____
<input type="checkbox"/> Genetic	Who? _____	Date: _____
<input type="checkbox"/> Other	Who? _____	Date: _____

Service Requested

Our primary area of service is to children with Autism or other Pervasive Developmental Disorders such as Asperger's and PDD-NOS. However, we have available staff to consult on other diagnostic and behavioral issues including children with mental retardation. Please check what kind of help/assistance is needed? **(Check only one)**

_____ Diagnostic Evaluation* for an Autism Spectrum Disorder

(One child only & Parent/Guardian/Primary Caregiver MUST be present) If the primary caregiver is NOT able to be in attendance, please reschedule for when the primary caregiver (s) is able to attend.

*Once the child is diagnosed, a diagnostic evaluation is not required for subsequent three-year re-evaluations.

_____ Classroom Observation/Recommendations for children with Autism/PDD.

On the date of this consultation, unless otherwise specified the following will be offered: 1). Observation of the student in his/her school environment; 2). Relevant School Personnel Interviews; 3). If needed, review of appropriate school records; 4). Follow-up meeting with relevant school personnel where recommendations are given. ** Written report will follow.

_____ Super Duper Evaluation.

This evaluation is for students with co-morbid disorders where there is diagnostic uncertainty (e.g., ADHD; SED; Bi-polar, Schizophrenia). Please be specific. For example, if there is a need for a differential diagnosis (e.g., Bi-polar vs. Autism); Immediate intervention for severe behavioral issues (e.g., severe aggression, unable to be maintained in current classroom setting); Functional Behavior Assessment/Behavior Intervention Plan. This service will be determined on a case-by-case basis. Attach other information if needed

_____ Transition Services.

Direct Service (e.g., assist in developing annual IEP goals, making transition goals functional; How to combine both academic and community experiences; how to develop specific strategies). Indirect Service (e.g., develop appropriate measurable postsecondary goals based on IDEIA; assist schools in developing working relationships with various community agencies; positive programming/positive supports). Transition program evaluation

****We realize that you may need more than one type of support but please only check one at this time. We can schedule a follow-up visit for other concerns subsequent to our first visit.**

School Questionnaire rev. 12/09

We ask that the Student's **Primary Teacher** complete this **School Questionnaire**. If appropriate, additional teachers observing similar behavioral concerns are welcome to complete additional copies of the School Questionnaire.

Child: _____

Name and Title* of person completing form: _____

School: _____

Type of Class** (exceptionality or regular): _____

Date Form Completed: _____

**We need the name/role of the person who completes this form. ** Preschool, Kindergarten, Resource, LD, MR, Regular, etc.*

Primary Presenting Problems of Child: (Be Specific)—List in order of importance

1. _____

2. _____

3. _____

Please Describe Behavioral Issues/Concerns in Detail.

If the child is a behavior management problem, what behavioral methods/strategies have you tried, and were they successful?

1. _____

2. _____

3. _____

What items or events have been used as reinforcers and which are motivating to the child?

- 1. _____
- 2. _____
- 3. _____

What three main learning or behavioral goals are you working on with this child in class?

- 1. _____
- 2. _____
- 3. _____

Please describe your program briefly - number of children, types of problems they have, schedule of activities, availability of support services.

What is the frequency of contact you have with the parents?

Signature of Individual completing form Date

What pleases you most about your child?

How can we be most helpful to you?

Signature of Individual completing form Date

Glenwood, Inc.
The Autism and Behavioral Health Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Campus Based Services

150 Glenwood Lane
 Birmingham, AL 35242
 (205) 969-2880 FAX (205) 967-1323

Community Education Program

150 Glenwood Lane (Lakeview Center)
 Birmingham, AL 35242
 (205) 212-6726 FAX (205) 212-6739

By signing this authorization, I, _____ authorize Glenwood, Inc. to obtain / disclose my individually identifiable health information to / from:

Disclose my health information to:

Name of Company or Person

Street Address

City State Zip

Obtain my health information from:

Name of Company or Person

Street Address

City State Zip

Health information that may be used or disclosed through this authorization is as follows:

_____ Entire record – all health information about me created by the Provider

_____ Specific health information

_____ Assessments

_____ Individual Support Plan

_____ Treatment Notes

_____ Treatment Summaries

_____ Health Service Referrals

_____ Medical Assessments

_____ Psychological Evaluations:

_____ Other: _____

_____ Medication Sheets

_____ Release/Consent forms

_____ Program Specific Information

_____ Discharge Summary

_____ Laboratory Reports

_____ Other: _____

The information for which I am authorizing disclosure will be used for the following purpose(s):

_____ sharing with other health care providers

_____ my personal use

_____ other: _____

This authorization expires on _____

Insert date or event

or within twelve (12) months from the date on which it was signed, whichever comes first.

Other Important Information

- ◆ I understand that I have a right to revoke this authorization at any time, by submitting written notice to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- ◆ I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- ◆ I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- ◆ I understand that I will receive a copy of this form after I have signed it.

Name: _____ ID: _____ DOB: _____

Signature of Client or Client Representative

Date

Name of Client Representative

Relation of Representative to Client

Signature of Witness

Date

Signature of Witness

(Second signature of Witness **Required** if client identifies with a mark or "X")

Date

