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.

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

Felicia Houston, Ph.D.

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

Transition Referral Form *rev. 12/09*
(This Form Must Be Included)
Demographic Information

Student: ______________________________

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

____ OT

____ Resource

____ Adaptive PE

____ Counseling

____ Physical Therapy

____ Social Work

____ School Nurse Services

____ Psychological Services

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.***

_____ **School evaluation** Who? ______________________ Date: ____________

_____ **Speech/Hearing** Who? ______________________ Date: ____________

_____ **Neurological** Who? ______________________ Date: ____________

_____ **Psychiatric** Who? ______________________ Date: ____________

_____ **Psychologist** Who? ______________________ Date: ____________

_____ **Occupational Therapist** Who? ______________________ Date: ____________

_____ **Physical Therapist** Who? ______________________ Date: ____________

_____ **Developmental** Who? ______________________ Date: ____________

_____ **Genetic** Who? ______________________ Date: ____________

_____ **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. Please check what kind of help/assistance is needed?

Transition Services
(Please check all that apply)

Direct Services

_____ Assist in developing annual IEP goals.
_____ Curriculum development
_____ How to make transition goals functional.
_____ How to make inclusion work.
_____ Staff Training.
_____ How to develop specific strategies.

Indirect Services

_____ Develop appropriate measurable postsecondary goals/ working with families.
_____ Assist in developing community partnerships (e.g., Vocational Rehabilitation).
_____ Positive programming/Positive supports.

Other:
____
____

*****Transition Program Evaluation**

Please note that evaluation of programming for students with annual IEP transition goals will include:

- A written comprehensive report highlighting strengths and offering suggestions for assessed areas of need.
- Modeling of various techniques used when working with children with Autism and direct feedback of strategies/methods implemented by staff.
- Conducting direct observations and interacting with the teachers, aides and students throughout their normal day, helping develop specific in-school as well as community based experiences for students.

School Questionnaire *rev. 12/09*

TRANSITION SERVICES

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.

Date Form Completed: ______________________________

Name of Student: ______________________________

Name and Title* of person completing form: ______________________________

School: ______________________________

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

Expected High School Graduation Date: ______________________________

Type of Diploma: ______________________________

Diagnostic History (please attach copies of relevant documents, including evaluation reports):

Student's ASD Diagnosis: Autism Asperger's PDD-NOS

Other: ______________________________

Name and title of professional who gave diagnosis: ______________________________

Additional Diagnoses (e.g., ADHD, Anxiety, Panic Attacks, Depression): ______________________________

____

____

Educational History (please attach copies of relevant documents, including IEP, transcripts, etc):

1. Current Grade: __________

2. Current Classroom Accommodations:

3. Academic Strengths/Best Subjects:

4. Academic Weaknesses/Difficult Subjects:

5. Types of Transition Services Received:

6. Please briefly describe the student's study skills and habits:

7. Please describe any extracurricular or academic activities student participates in:

Adaptive Skills:

1. Work History: This may involve school jobs (e.g., working in library, cafeteria clean-up, etc.)

2. Does the student (please elaborate when necessary):
   a. Use a schedule book, PDA, etc.?
   b. Use public transportation?
   c. Wash and dry their clothes?

d. Do any cooking (using microwave or stove)?

e. Shop for clothing, food, other needed items independently?

3. Please briefly describe student's strengths and weaknesses in daily living skills and independence:

Information Regarding Social Interactions:

1. Please briefly describe student's strengths and weaknesses in social interactions:

2. Please briefly describe student's current friendships and social activities:

Please use the remaining space to provide any additional information regarding the student, this application, etc.

Signature/Title of Person Completing this Form　　　　Date

Parent Questionnaire *rev. 12/09*
TRANSITION SERVICES

To be completed by ALL Primary Caretakers

(Please make as many copies as needed)

Form Completed By: ______________________________

Relationship to Child: ______________________________

Child's Name: ______________________________

Date Completed: ______________________________

Please fill out this form as fully and freely as you can. Use additional pages if needed. Like all information we request, this will be treated confidentially.

Employment

1. Has your child had any type of vocational exploration or work experience?

2. Do you think your child will gain employment?

3. If so, what type of job do you see your child gaining?

4. In your opinion, what will be the biggest obstacle in your child gaining employment?

Community/Leisure

1. How many times does your child go into the community a week?

2. What types of places does your child go to in the community (e.g. restaurants & stores)?

3. What does your child like to do for leisure activities?

Functional skills

1. Can your child independently dress himself/herself?

2. Can your child fix his/her own meals? If so, please give examples.

3. Does your child understand the concept of time? Please explain.

Self-determination

1. Does your child make choices? If yes, please provide examples.

2. Does your child know he/she has a disability? If so, please explain

Behavior

1. Does your child have any behavioral issues that could affect his/her independence?

Concerns

Primary Presenting Concerns of Child: (Be Specific)

1. ______________________________

____

____

2. ______________________________

____

____

3. ______________________________

____

____

What are your concerns for your child after graduation?

____

Signature of Individual completing form Date