

**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.