School Medical Autism Review Team

Packet Checklist

Child's Name:	DOB:
Primary Care Provider & Location:	
School District & School Name	

Today's Date: ____/____/____

Packet Forms:

- ❑ Authorization form release of records
- ❑ Demographics form
- ❑ Smart Tools, filled out by (choose all that apply):
    - ❑ Parent
    - ❑ General Education Teacher
    - ❑ Special Education Teacher
    - ❑ Speech Language Pathologist
    - ❑ Occupational Therapist
    - ❑ School Psychologist
    - ❑ Daycare Provider
    - ❑ Other (Birth to three, Children with Special Healthcare Needs, Healthcare coordinator, Home visitor,
    - ❑ 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
- ❑ IFSP (Birth to 3 report)
- ❑ Copies of 504 plans or IEP's
- ❑ Reports of previous evaluations by physicians, psychologists, or psychiatrists

SAMPLE