



Dear Colleague,

Glenwood, Inc., is dedicated to providing quality services to public schools in Alabama. As the 2015-2016 academic year begins, we would like to provide you with information regarding our state contracted services available to public schools in Alabama. In our continued partnership with the Alabama Department of Education, Glenwood Inc. continues to provide several services including diagnostic assessment for children who may have an Autism Spectrum Disorder. Our Consultation and Training Specialists also provide research-based recommendations tailored to individual students and classrooms. Additionally, Glenwood, Inc. is contracted to provide consultation for students presenting with significant behavioral or mental health concerns that are receiving Special Education Services under the category of Emotional Disturbance and/or Other Health Impaired on a case-by-case basis.

Our updated referral packet is included with this letter. Please discard previous referral packets, as they include outdated service information and contact information. We look forward to serving your students, staff, and families. Should you have questions about completion of the packet, please contact Shirley Kelley, M.A. at skelley@glenwood.org for clarification and/or questions.

Send the completed packet to:
Glenwood, Inc. Community Education Programs
Lakeview Center
Attention: Shirley Kelley, Director of CEP
150 Glenwood Lane
Birmingham, Alabama 35242
Phone (205) 212-6726
E-Mail: skelley@glenwood.org

Sincerely,

Shirley Kelley, M.A.

Shirley Kelley, M.A.
Director of Community Education Program



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 an Autism Spectrum Disorder. Additionally, we provide consultation focused on classroom suggestions and teaching strategies for a specific child in your classroom.

In conjunction with our emphasis on children with Autism Spectrum Disorders, Glenwood employs several specialists who are able to provide school systems or classroom teachers' assistance with or assessment for children with emotional/behavioral problems, which would fall under the special education category of Emotional Disturbance and/or Other Health Impaired.

If you are requesting a diagnostic evaluation or specific behavioral intervention, 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 best practice 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 Shirley Kelley, skelley@glenwood.org for clarification and/or questions.

TO SCHEDULE YOUR APPOINTMENT, WE WILL NEED THE FOLLOWING INFORMATION:

- Consult Information Form
- History and Current Placement Form
- Current IEP (if relevant)
- Current IQ evaluation (If relevant)
- Speech language evaluation with Expressive Language Equivalent
- Evaluation by other agencies/doctors
- School Questionnaire
- Directions to your school

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Sincerely,

Shirley Kelley, M.A.

Shirley C. Kelley, M.A.

Shirley Kelley, M.A.
Director of Community Education Program

Consult Information Form rev. 06/15

(This Form Must Be Included)

Demographic Information

Student: _____ DOB: _____

Grade: _____ Gender: ___M___F Ethnicity: _____

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

Name of Individual (s) Child resides: _____

Home Address: _____

City/State/Zip: _____

Resident County: _____

Home Phone Number: _____

Work Phone Number: _____

Cell phone Number: _____

SCHOOL INFORMATION:

*****Referral packet will not be considered complete without the following information*****

Name of School Child Attends: _____

Name of School System: _____

Name of County: _____

School Phone Number: _____

School Street Address: _____

School Physical Mailing Address (If different from above)—Please **DO NOT give PO Box** as address.

Referral requested by: _____ School Personnel at the request of the parent/guardian

_____ School Personnel/Position _____

_____ Other _____

Name of school personnel making referral: _____

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

Main Contact Person Phone Number (Please provide two viable contact numbers. For example, if you are with the BOE, do not give the school number as a viable number if you do not have an office at the school)

Contact # _____

Contact # _____

E-mail Address of main Contact Person: _____

**Will the main contact person be available at the school on the day of the consult ____ YES ____ NO

**If No, who will be the contact person at the school on the day of the consult? Also add contact number and email address for this person: _____

LOGISTICS: **Please complete the following information****

1. Is this an initial referral? ____ NO ____ YES: If yes, what is the start date of the timeline _____ days.

2. Is this referral part of any of the following?

_____ Mediation Agreement

_____ Due Process

_____ ADAP

_____ DHR/other State or government agency

_____ Second Opinion

_____ Other:

Name and Address where Confirmation Letter needs to be sent: (This can be faxed, scanned, emailed, or regular mail:

REPORT: *Please provide the following information*****

Name and Address where written report is to be mailed: **Parents MUST obtain report from the school.

For Office Use Only

Service Requested: _____

Timeline? YES NO

Date Referral Received: _____

Date of Consult: _____

Has client been seen at Glenwood before? _____

Time of Consult: _____

Client Number: _____

Consultant: _____

MHC? _____N_____

Date Confirmed: _____

SAC? _____N_____

Date Cancelled: _____

MRC? _____N_____

Date if Rescheduled: _____

Other: _____

Current Placement and Educational Services (rev. 08/14) - 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
☐ Intellectual Disability
☐ Learning Disorder
☐ Attention-Deficit Hyperactivity Disorder (ADHD)
☐ Oppositional Defiant Disorder (ODD)
☐ Conduct Disorder
☐ Seizure disorders
☐ Bi-polar Disorder
☐ Schizophrenia
☐ 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 Spectrum Disorders such as Asperger's and PDD-NOS. However, we have available staff to consult on other diagnostic and behavioral related to other special education categories such as Emotional Disturbance. 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.

_____ Other Diagnostic Evaluations for Special Education Eligibility.

This evaluation is for students with educational Emotional Disturbance (e.g., SED; Schizophrenia). Please be specific.

1. _____ Diagnostic Clarity for special education eligibility
2. _____ Immediate intervention for severe behavioral issues (e.g., severe aggression, behaviors adversely impacts current educational functioning)
3. _____ Functional Behavior Assessment/Behavior Intervention Plan.

This service will be determined on a case-by-case basis. Attach other information if needed

****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. 08/14

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/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 Concerns: (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 contacts you have with the parents?

Parent Questionnaire rev. 08/14
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.

Primary Presenting Concerns of Child: (Be Specific)

1. _____
2. _____
3. _____

Reason for referral (Why are you seeking services at this point in time?)

What pleases you most about your child?

How can we be most helpful to you?

Directions from Birmingham, AL to your school
We must have directions before an appointment can be made.

Start from 150 Glenwood Lane, Birmingham, AL 35242

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

Directions from Huntsville, AL to your school
We must have directions before an appointment can be made.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Glenwood, Inc.
The Autism and Behavioral Health Center
150 Glenwood Lane
Birmingham, Alabama 35242-5700

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Campus Based Services

(205) 969-2880 FAX (205) 795-3359

Educational Services Division

(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 (Receiver):

Obtain my health information from (Provider):

Name of Company or Person

Name of Company or Person

Street Address

Street Address

City State Zip

City State Zip

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

Check specific description of requested 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: _____

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

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 Individual Served or Individual Served Representative

Date

Name of Individual Served Representative

Relation of Representative to Individual

Signature of Witness

Date

Signature of Witness

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

Date

REMINDER CHECKLIST

*****PLEASE NOTE THAT ALL THE REQUESTED INFORMATION MUST BE RECEIVED BEFORE A CONSULTATION APPOINTMENT CAN BE SCHEDULED.**

- _____ 1ST AND 2ND page of the Consult Information Form
- _____ Directions to school (Consultant will be using GPS)
- _____ Release and Consent for Information Form
- _____ Name, Mailing Address, and Email Address to send confirmation letter
- _____ Name, Mailing Address, and Email Address to send report
- _____ School Questionnaire
- _____ Current IEP (If applicable)
- _____ Current IQ evaluation