

Northwest Regional ESD

5825 NE Ray Circle

Hillsboro, OR 97124

Phone: 503-614-1470 | Fax: 503-614-1285

Referral Date: _____

Request for Contracted AC/AT Services

REQUESTED SERVICE: CONSULTATION

Enter requested hours

<input type="checkbox"/> Consultation To Staff (1 st step – prior to formal evaluation request)	Up to 5 hours	
TOTAL HOURS REQUESTED		

CONTACT INFORMATION

Case Manager Name/ Title / Teacher:	
Case Manager eMail:	Case Manager Phone Number:
Speech Language Pathologist (AC):	Occupational Therapist (AT):
Speech Language Pathologist Phone Number:	Occupational Therapist Phone Number:
Speech Language Pathologist eMail:	Occupational Therapist eMail:

Required Attachments for Consultation:	Return completed form via courier, fax, or email to:
<input type="checkbox"/> Description of access needs in the classroom	NWRES D Attention: AC/AT Program 5825 NE Ray Circle, Hillsboro, OR 97124 Phone: 503-614-1470 Fax: 503-614-1285 eMail: acatreferral@nwresd.k12.or.us
<input type="checkbox"/> Current list of tools available in district	
<input type="checkbox"/> Implementation data (if available)	

School District Administrator Signature

Date

NWRES D OFFICE USE ONLY		
_____ <i>Date Referral Received</i>	_____ <i>Date Assigned</i>	_____ <i>Assigned To</i>
Check Applicable: Funding: <input type="checkbox"/> Existing hours: <input type="checkbox"/> Link to Form 30		