REQUEST FOR CONSULTATION

DAUPHIN COUNTY EARLY INTERVENTION

SECTION 1 (To be completed by person requesting consult)

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| **Date of Request** | **Child’s Name**  | **BSU #** | **Service Coordinator** | **Person Requesting Consult/Title** |
|  |  |  |  |  |

**Type of consultation requested: ☐SI ☐Hearing ☐Vision ☐Nutrition ☐ Music Therapy**

 **☐ Behavior ☐OT ☐PT ☐ST ☐ AAC ☐Social Work**

**Considerations when making a request:**

* Are you looking for strategies only? ☐Yes or ☐No
* Is the rest of the team aware of the possible need/request for a consult? ☐Yes or ☐No
* Is there a current team member who could address the need without a consult? ☐Yes or ☐No

**Please provide the following information for the person doing the Consult:**

**Reason for consultation/ questions to be addressed / what has already been tried and results?**

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| --- |
| Zamir is 30 months old. He is a twin. His older brother is diagnosed with autism. Zamir is demonstrating characteristics of autism. He has been receiving SI services over the last 5-6 months. Zamir has a limited diet. He will ear chicken nuggets and French fries. He recently started accepting apple sauce pouches and some yogurt. Mom notes that he has been more willing to try some new foods. SI/mom note that he takes a long time to warm up to new things and situations. He was initially not interested in his bumper car, but now loves it. When SI put a different cereal in his sensory bin, he picked it out.  |
|  |

**IFSP Drives Service: Strategy the SC will add to existing outcome to support consult service requested:**

**(e.g. “explore how to support feeding needs” or “explore ways to support walking”)**

OT consult will be held to explore strategies to encourage Zamir to eat a wider variety of foods and be accepting of new foods and experiences

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Date Sent to Service Coordinator:

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**Guidelines for person completing the consult**:

* Review IFSP for current outcomes and services (SC must assign access to plan)
* Record the results of the consult in a session note
* Contact the SC within 24 hours with results of the consult in regards to services.
* Send consult form and copy of session note via email to SC within 7 calendar days.
* Review and/or complete the reverse side of this form only if SC is not in attendance.
* SC will contact family regarding the recommendations and will begin new referral for service if needed.

Section 2 (To be completed by consulting therapist)

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| **Date of Consultation:** | **Person/Therapist completing the consultation:**  | **Individuals present at the consultation:** |
|  | **Print & sign** |  |
|  |  |  |
|  |  |  |

**If the SC is not in attendance, complete the information below for the team to consider.**

**Please add potential new outcome for identified needs or additional strategies recommended for an existing outcome below.**

☐New outcome? OR ☐Additional strategies?

***Outcome Phrase***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Outcome Goal/Statement***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***What is happening now****?*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***What teaching strategies are needed to reach the outcome/goal****?*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***How will we as a team measure progress and collect data for this outcome/goal?***

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**FINAL QUESTIONS:**

1. Can a current team member support this need? ☐Yes or ☐No

Team member name for SC to discuss with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is a new service recommended? ☐Yes or ☐No

Service type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Are you available to do on-going service? ☐Yes or ☐No

If yes, SC will contact you once consult is received and discussed with family.