eMail Form | Print Form | Reset Form

**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*

| | | |
|---|---|---|
| ☐ Consultation To Staff (1st 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:** |
|---|---|
| ☐ **Description of access needs in the classroom** | NWRESD<br>Attention: AC/AT Program<br>5825 NE Ray Circle, Hillsboro, OR 97124<br>Phone: 503-614-1470 \| Fax: 503-614-1285<br>eMail: acatreferrals@nwresd.k12.or.us |
| ☐ **Current list of tools available in district** | |
| ☐ **Implementation data (if available)** | |

_____ _____

*School District Administrator Signature* *Date*

**NWRESD OFFICE USE ONLY**

_____ _____ _____

*Date Referral Received* *Date Assigned* *Assigned To*

Check Applicable: Funding: ☐ | Existing hours: ☐ | Link to Form 30

*Revised 5/02/2016*