

Autism Spectrum Disorder
MULTIDISCIPLINARY EVALUATION TEAM (MET) SUMMARY
Ionia County Intermediate School District

Student Name: _____ MET Report Date: _____

Birthdate: _____ Grade: _____ School Building: _____

School District: _____ Parent/Guardian: _____

PURPOSE

This form will be used by the Multidisciplinary Evaluation Team (MET) to recommend: (Choose One)

- Initial eligibility** for special education **Change of eligibility** for special education

EVALUATION FINDINGS AND DOCUMENTATION

The following information and documentation is required to determine eligibility for special education as a student with Autism:

<u>Required Information*</u>	<u>Evaluator/Date</u>
Diagnostic Report(s)	_____
Relevant behavior observations	_____
Communication functioning	_____
Information from parents/guardian	_____

**Attach all referenced documents and Referral For Special Education Evaluation to this page*

DIAGNOSTIC ASSURANCE STATEMENTS

The Multidisciplinary Evaluation Team must consider the following assurance statements before making a recommendation regarding this student's eligibility:

- There is evidence, typically before 36 months of age, of a lifelong developmental disability that adversely affects the student's educational performance in 1 or more of the following: Academic Social Behavior. A child who first manifests the characteristics after age 3 may also meet criteria.
- The suspected autism spectrum disorder is characterized by qualitative impairments in reciprocal social interactions, communication, restricted range of interests/repetitive behavior and ALL of the following:
 - ⇒ The qualitative impairment in reciprocal social interactions and **at least 2** of the following:
 - Marked impairment in the use of multiple non-verbal behaviors such as eye-to-eye gaze, facial expression, postures, and gestures to regulate social interaction.
 - Failure to develop peer relationships appropriate to developmental level.
 - Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people.
 - Marked impairment in areas of social reciprocity.
 - ⇒ Qualitative impairments in communication including **at least 1** of the following:
 - Delay in, or total lack of development of spoken language not accompanied by an attempt to compensate through alternative methods such as gesture or mime.
 - Marked impairments in pragmatics or in the ability to initiate, sustain, or engage in reciprocal social conversations with others.
 - Stereotyped and repetitive use of language or idiosyncratic language.
 - Lack of varied, spontaneous make-believe or social imitative play appropriate to developmental level.
 - ⇒ Restricted, repetitive and stereotyped behaviors including **at least 1** of the following:
 - Encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
 - Apparently inflexible adherence to specific, nonfunctional routines or rituals.
 - Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole-body movements.
 - Persistent preoccupation with parts of objects.
- May include unusual or inconsistent response to sensory stimuli.
- The suspected disability is not due to characteristics associated with schizophrenia such as delusions, hallucinations, loosening of associations and incoherence.
- The suspected disability is not due to the lack of instruction in reading, math or limited English proficiency.
- This student requires special education programs/services under this eligibility area. yes no

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(Continued)

PRESENT LEVEL OF EDUCATIONAL PERFORMANCE

With enough detail to determine a starting point for instruction, describe this student's present level of educational performance and educational needs, including a description of how the disability affects his/her progress in the general curriculum (or participation in appropriate activities for preschool students.)

ELIGIBILITY RECOMMENDATION

Based upon the above data, it is our opinion that the above student is: **Eligible** **Ineligible** as having **Autism Per R.340.1715.**

Team Members:

Psychologist/Psychiatrist _____ Speech Pathologist _____

School Social Worker _____ Other/Title _____

Minority Report attached (if needed): _____ Signature/Title _____