

MULTIDISCIPLINARY EVALUATION TEAM (MET) REPORT



**AUTISM SPECTRUM DISORDER
(R340.1715)**

Alpena-Montmorency-Alcona
Educational Service District
2118 US 23 South
Alpena, MI 49707
(989) 354-3101

STUDENT: _____ MET DATE: _____
DOB: _____ SCHOOL: _____

TYPE OF EVALUATION:

INITIAL DATE OF LAST RE-EVALUATION IEP TEAM MEETING: _____
 OTHER _____

The multidisciplinary evaluation team must use the statements below as a basis for making a recommendation of eligibility.

1. Is the student's educational performance affected in any of the following areas?

a. Academic No Yes, explain _____

b. Behavioral No Yes, explain _____

c. Social No Yes, explain _____

2a. Qualitative Impairments in Reciprocal Social Interactions

i Does this child display a marked impairment in the use of non-verbal behaviors such as:
Eye-to eye gaze No Yes _____

Facial expression No Yes _____

Body postures No Yes _____

Gestures No Yes _____

ii Does the child fail to develop peer relationships at an appropriate developmental level?
 No Yes, describe _____

iii Does the child exhibit a marked impairment in spontaneously seeking to share enjoyment, interests, or achievements with other people?

No Yes, describe _____

iv Does the child show a marked impairment in the areas of social or emotional reciprocity?

No Yes, describe _____

2b. Qualitative Impairment in Communication

i Does the child exhibit any delay in or total lack of language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime?

No Yes, describe _____

ii Does the child exhibit a marked impairment in pragmatics or the ability to initiate, sustain or engage in reciprocal conversations with others?

No Yes, describe _____

iii Does the child exhibit stereotypic and repetitive use of language or idiosyncratic language?

No Yes, describe _____

iv Does the child exhibit a lack of varied, spontaneous make-believe play, or social imitative play appropriate to his/her development level?

No Yes, describe _____

2c. Restricted, repetitive and stereotyped behaviors

i Does the child exhibit an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal in intensity or focus?

No Yes, describe _____

ii Does the child exhibit an apparent inflexible adherence to specific non-functional routines or rituals?

No Yes, describe _____

iii Does the child exhibit stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole body movements)?

No Yes, describe _____

iv Does the child exhibit a persistent preoccupation with parts of objects?

No Yes, describe _____

3. Does the student exhibit any unusual or inconsistent response to sensory stimuli?

No Yes, describe _____

4. At what age(s) if any, did the child first manifest the characteristics of Autism Spectrum Disorder?

Age _____ qualitative impairments in reciprocal social interactions (Question 2a)

Age _____ qualitative impairments in communication (Question 2b)

Age _____ restricted range of interests or repetitive behaviors (Question 2c)

ELIGIBILITY DECISION:

A. Does the student have a primary diagnosis of schizophrenia or emotional impairment?

NO YES, therefore the student is **NOT** eligible under R340.1715

B. Is any one area of Question 1 checked "Yes"?

YES NO, if **NO** the student is **NOT** eligible under R340.1715

C. Are at least two of the sub areas of Question 2a (Reciprocal Social Interactions) checked "Yes"?

YES NO, if **NO** the student is **NOT** eligible under R340.1715

D. Is at least one area indicating a qualitative impairment in communication (Q 2b) checked "Yes"?

YES NO, if **NO** the student is **NOT** eligible under R340.1715

E. Is at least one area indicating repetitive and stereotypical behaviors (Q 2c) checked "Yes"?

YES NO, if **NO** the student is **NOT** eligible under R340.1715

RECOMMENDATION: Does the student meet all the criteria of rule R340.1715 for eligibility for Autism Spectrum Disorder? **YES** **NO**

MEMBERS OF THE MULTIDISCIPLINARY EVALUATION TEAM

Required members:

Psychologist or Psychiatrist _____

Speech and Language Provider _____

School Social Worker _____

Other Members (title and name):

Other Recommendations for programs/services: _____

Indicate below any team members who disagree with this decision and attach minority reports.

