



**Hospital for
Special Care**

We rebuild lives.

Submit all documents to:

Autism Admissions
Coordinator: Kayla Santiago

Ksantiago@hfsc.org

P: 860-827-4841

F: 860-832-6273

Hospital for Special Care Autism Inpatient Unit Referral Form

Date: _____

(Please note all referrals must come from an MD)

Patient's Demographic Information

Patient's Name:		Date of Birth:	Age:
Address/City/State/Zip:			
Preferred Name:	Preferred Pronouns:	Gender assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender <input type="checkbox"/> Other _____ <input type="checkbox"/> Choose not to disclose		Sexual Orientation: <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Lesbian/Gay/Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't know <input type="checkbox"/> Other _____ <input type="checkbox"/> Choose not to disclose	
Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican/Mexican American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose			
Patient Primary Language:		Parent Primary Language:	
Height:	Weight:	Patient is: <input type="checkbox"/> Verbal <input type="checkbox"/> Nonverbal	
Primary Contact:		Relationship to Child:	
Phone:	Cell:	Email:	
Secondary Contact:		Relationship to Child:	
Phone:	Cell:	Email:	
Custody Arrangement: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> Other Guardian _____			
If 18 or older, is the patient conserved: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			
DCF Involvement: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Voluntary <input type="checkbox"/> Past Involvement (please specify) _____			
DDS Involvement: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, contact information) _____			

Insurance Information:

Please attach a copy of the insurance card

Primary Insurance:		ID#:	
Subscriber Name:		Relationship:	DOB:
Subscriber Phone:		Subscriber Address:	
Secondary Insurance:		ID#:	
Subscriber Name:		Relationship:	DOB:
Subscriber Phone:		Subscriber Address:	



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Referral Information: (Please note all referrals must come from an MD)

Referring MD: _____ Specialty: _____

Facility: _____

Phone #: _____ Fax #: _____

Diagnosis: _____

Autism Diagnostic Evaluation (Note: Must attach written report of evaluation by a Psychologist or MD, outside of school, who used one of the following tests to diagnose Autism: CARS, GARS, or ADOS)

Reason for Referral:

Problem Behaviors (Please include duration, Frequency and day of last incident

☐ Self-Injury ☐ Property destruction ☐ Aggression ☐ Elopement Risk ☐ Suicidal Ideation ☐ Sexualized behaviors

Safety Concerns:

Current Services (Respite, in-home ABA, etc):

Anticipated goals of program and discharge plan:



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Patient's Current Medications:

Medication	Schedule	Prescribing MD

Please list any known drug or environmental allergies or sensitivities:

Current Diet and Food Allergies

☐ **No Known Food Allergies**

Does the child have any preexisting and/or current medical diagnoses? Are there any medical procedures or equipment the child needs on a regular basis? If yes, what are they? (i.e., Diabetes, GERD, CPAP, wound care, AFOs):

Signature

Print Name

Date

Discharge planning:

My client will be returning under my care after discharge _____ (initial).

Please provide the following with your referral:

- ☐ Insurance card(s) front & back
- ☐ Pertinent Office Notes/Lab Results
- ☐ Parent/Guardian Questionnaire Form
- ☐ Educational Testing and latest IEP
- ☐ ASD Testing
- ☐ Current Medication list
- ☐ Copy of Legal Guardian or Conservator document if patient is 18+ years of age