



# The Autism Center Clinical Referral Form

Date \_\_\_\_\_

Referring Physician Name	NPI #	Phone/Fax #
PCP Name		Phone/Fax #

**Patient Information**

Patient Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_

Patient Phone # Home \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Email \_\_\_\_\_ Primary Language \_\_\_\_\_

Interpreter Needed?  Yes  No \*child must understand English

Ethnicity  Hispanic  Non-Hispanic

Race  American Indian  Asian/Pacific Islander  African American  Hispanic  
 Caucasian  White  Other \_\_\_\_\_

**Type of Referral**

Psychiatry/Medication Management

Psychological Testing (prescription required\*\*)

Dev Peds-only for question of ASD or 2<sup>nd</sup> opinion - ages 2-5 years old

Family Therapist

Occupational Therapy (prescription required\*\*)

Speech Therapy (prescription required\*\*)

eating/feeding  expressive-receptive language  Augmentative Alternative Communication (AAC)  social language

Degree of Urgency:  Routine  Urgent (recent hospitalization/ED visit)  Priority: 1<sup>st</sup> Birthday to 3 years of age

Reason for Referral \*REQUIRED\* referral will not be processed if this section not completed

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last Physical Exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Current Diagnosis \_\_\_\_\_

Current Medications \_\_\_\_\_

**Relevant Background (check all that apply)**

<input type="checkbox"/> delayed speech and language	<input type="checkbox"/> avoids eye contact	<input type="checkbox"/> does not point or respond to pointing
<input type="checkbox"/> lines up toys or other objects	<input type="checkbox"/> does not respond to their name	<input type="checkbox"/> ignores minor injuries
<input type="checkbox"/> does not point at objects to show interest	<input type="checkbox"/> gets upset by minor changes	<input type="checkbox"/> does not play "pretend" games ("feed" a doll)
<input type="checkbox"/> has obsessive interests/routines	<input type="checkbox"/> overreacts to certain sounds	<input type="checkbox"/> licks non-food items
<input type="checkbox"/> smells things w/o obvious odors	<input type="checkbox"/> plays with toys the same way each time	



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## Insurance Information

Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_

Guarantor \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Secondary Insurance \_\_\_\_\_ ID # \_\_\_\_\_

## Required Documents/Information

Information REQUIRED from referring clinician for release of appointment date

- \*\*MD Order for Psychological Testing, Speech &/or OT(can be written on a prescription pad)
- Pertinent Office Notes/Specialist & Consult Notes/ Most current lab results

Please inform parent/guardian that receipt of the following documentation is required for release of an appointment date

- For children under the age of 5y/o: M-CHAT, most recent B-3 consult note, current IEP/504 (if applicable)
- For children over the age of 5y/o: previous psychological and/or educational testing & current IEP/504 (if applicable)

Parent/Caregiver Primary Concern

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## History/Records Information

School \_\_\_\_\_

Other Services \_\_\_\_\_

Has child ever had psychological testing before?  \*Yes  No \*must be submitted for release of appointment date

If yes, when & where \_\_\_\_\_

## PLEASE FAX REQUIRED INFORMATION ALONG WITH THIS REFERRAL FORM TO 860-612-6384

Referred by \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Self-Referred (parent)

Please let us know how you heard of us:  Print  Website  Connection  Other \_\_\_\_\_