



Date: _____

Patient's Demographic Information:

Patient Name: _____ DOB: _____ Age: _____

Address: _____

Gender: M F Height: _____ Weight: _____ Patient is: Verbal Nonverbal

Primary Contact: _____ Relationship: _____

Phone # (H): _____ (Cell): _____ Email: _____

Custody Arrangement: Mother Father Joint Other Guardian: _____

DCF Involvement: No Yes Voluntary Past Involvement (Please specify): _____

DDS Involvement: No Yes (If yes, contact information): _____

Ethnicity: Hispanic Non-Hispanic

Race: American Indian Asian/Pacific Island Black White Other Prefer not to answer

Patient's Primary Language: _____ Parent's Primary Language: _____

Insurance Information:

Please attach a copy of the insurance card

Primary Insurance: _____ ID# _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ ID# _____

Subscriber Name: _____ Relationship: _____ DOB: _____

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

Referring MD: _____ Specialty: _____

Facility: _____

Phone #: _____ Fax #: _____

Diagnosis: _____

Documentation of Autism Testing (NOTE: CT residents must attach documentation of evaluation by a Psychologist, 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 date 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:

Child'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):

Signature

Print name

Date

Please provide the following with your referral:

- ASD Testing
- Pertinent Office Notes/Lab Results
- Educational Testing and latest IEP
- Current medication list