hfsc Hospital for Special Care

Hospital for Special Care Autism Inpatient Unit
ED/Hospital Referral Form

Matt Catalano
mcatalano@hfsc.org
860-827-4865p
860-832-6273 f

Date: _____ Date of ED Visit: _____

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:

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: 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:

Hospital for Special Care Autism Inpatient Unit
ED/Hospital Referral Form

Matt Catalano
mcatalano@hfsc.org
860-827-4865p
860-832-6273 f

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:

Hospital for Special Care Autism Inpatient Unit
ED/Hospital Referral Form

Matt Catalano
mcatalano@hfsc.org
860-827-4865p
860-832-6273 f

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 (if applicable):

- Psychiatric evaluation
- Documentation of testing for ASD
- Pertinent Office Notes/Lab Results
- Current medication list
- ED Discharge Summary