Hospital for Special Care

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**)

ABA Therapy (ADOS or CARS required*)

Psychotherapy/Social Work

Occupational Therapy (prescription required**)

Physical 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: 1st Birthday to 3 years of age

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

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Date of last Physical Exam ____/____/____ Current Diagnosis ______________________

Current Medications ______________________

Relevant Background (check all that apply)

delayed speech and language

lines up toys or other objects

does not point at objects to show interest

has obsessive interests/routines

smells things w/o obvious odors

avoids eye contact

does not respond to their name

gets upset by minor changes

overreacts to certain sounds

plays with toys the same way each time

does not point or respond to pointing

ignores minor injuries

does not play "pretend" games ("feed" a doll)

licks non-food items

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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

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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 ______________________ Signature ______________________

Phone ______________________ Fax ______________________

Self-Referred (parent)

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