hfsc 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

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 _____

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

hfsc Hospital for Special Care

# The Autism Center Clinical Referral Form

## 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 _____ Signature _____

Phone _____ Fax _____

Self-Referred (parent)

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