



Outpatient Autism Services Referral Form

DATE: \_\_\_\_\_

Referring Physician Name NPI # Phone / Fax #

PCP Name Phone / Fax #

Patient Information

Patient Name DOB / / Age
Patient Phone # Home Cell
Home Street Address City State Zip
Emergency Contact Phone Relationship
Email Address Primary Language
Gender: Male Female Interpreter Needed? YES NO
Ethnicity: Hispanic Non-Hispanic
Race: American Indian Asian/Pacific Islander African American Hispanic Caucasian/White
Other: \_\_\_\_\_

Type of Referral Requested

- Psychiatry / Medication Management (ADOS, CARS or GARS report will be required to schedule)
Psychological Testing / Autism Assessment (Prescription Required\*\*\*)
Psychotherapy / Social Work / RUBI Parent Training
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 is not completed)
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Date of last physical exam / / Current Diagnosis

Current Medications



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Insurance Information a

Primary Insurance ID#
Guarantor DOB: Relationship
Secondary Insurance ID#

Required Documents/Information \*\*\*REQUIRED\*\*\*

Information REQUIRED from referring clinician for release of appointment date
\*\*\*Pertinent Office Notes/Specialist and Consult Notes / Most current lab results\*\*\*

Please inform parent/guardian that receipt of the following documentation is required for release of an appointment
- 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, and current IEP/504 (if applicable)

Parent/Caregiver Primary Concern: \*\*must be completed\*\*

History/Records Information

School
Other Services
Has the child ever had psychological testing before? \*YES No \*must be submitted prior to the appointment
If yes, when and where:

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

Referred by:
MD SIGNATURE:
Phone: Fax: