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Submit all documents to:
Autism Center
php@hfsc.org
P: 860-612-6312
F: 860-612-6384

PHP Referral Form- Parent or Clinician

Today's date: _____ Referral source: _____

Patient's Demographic Information:

Patient's Name: _____ **Patient's DOB:** _____ **Age:** _____

Address: _____

Gender: ☐M ☐F ☐Trans M ☐Trans F ☐Nonbinary

Race: ☐American Indian ☐Asian/Pacific Islander ☐Black/African American ☐White
☐Other: _____ ☐Prefer not to answer

Ethnicity: ☐Hispanic ☐Non-Hispanic

Patient's preferred language: ☐English ☐Spanish ☐ASL ☐Other:_____
Interpreter needed: ☐Y ☐N

Patient's current location: ☐Home ☐ED (where? _____) ☐Inpatient (where? _____)

Parent/Guardian Information:

Primary Contact: _____ **Relationship to patient:** _____

Legal Custody: ☐Married parents ☐Mother ☐Father (Married ☐Y ☐N)
☐Joint or Sole Custody? ☐DCF ☐Conservator: _____
☐Guardian: _____ ☐Other:_____

Parent/Guardian's preferred language: ☐English ☐Spanish ☐ASL ☐Other:_____
Interpreter needed: ☐Y ☐N

FATHER:_____

Mailing Address (if different from patient):
_____

Email address: _____

Preferred Phone #: _____ Type: ☐C ☐W ☐H

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MOTHER:_____

Mailing Address (if different from patient):

_____

Email address: _____

Preferred Phone #: _____ Type: ☐C ☐W ☐H

Secondary Contact: _____ **Relationship:** _____

Mailing Address: _____

Preferred Phone #: _____ Type: ☐C ☐W ☐H

Insurance Information:

Primary Insurance: _____ ID #: _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ ID#: _____

Subscriber Name:_____Relationship:_____DOB:_____

Patient Clinical Information:

Date of ASD diagnosis: _____ **Name of clinician:** _____

Diagnosed by: ☐Birth-to-Three ☐School Psychologist ☐Psychiatrist/Neurologist
☐Other: _____

Can provide report documenting Autism diagnosis with ADOS/CARS/GARS? ☐Yes ☐No

Additional diagnosis:

☐Intellectual Disability ☐Down syndrome ☐ADHD ☐DMDD ☐Anxiety
☐Depression ☐Reactive Attachment Disorder ☐Other:_____

Grade: _____**School name:** _____**School district:** _____

Patient has: ☐IEP ☐504 ☐None ☐Patient not attending school

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Patient communicates via: ☐Sentences ☐Single Words ☐Sign/gestures ☐AAC device ☐Other: _____

Does patient have any of the following impairments: ☐Vision ☐Hearing ☐Mobility/Physical

Patient requires assistance with: ☐Dressing ☐Toileting ☐Handwashing

What are the primary behavior problems? ☐Aggression ☐Verbal threats to others ☐SIB ☐Property destruction ☐Suicidal ideation/attempts ☐School refusal ☐Sexualized behaviors ☐Other (specify): _____

Does patient have any history of legal involvement? ☐Arrest ☐Probation ☐Detention ☐None

Legal contact if applicable: _____

Has patient ever been to the emergency room for his/her behavior?

Dates	Hospital	Reason	Outcome

Has patient ever been on an inpatient unit for his/her behavior?

Dates	Hospital	Reason	Outcome

Current medications

Medication	Start date	Dose/Schedule	Prescriber

Allergies? ☐N ☐Y: _____

Does patient have any major medical problems? ☐Seizures ☐Diabetes ☐Asthma ☐Other: _____

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Current services:

	Name/Agency	Phone number
PCP/Pediatrician	_____	_____
Psychiatrist	_____	_____
Neurologist	_____	_____
ABA therapy at home	_____	_____
Individual therapist	_____	_____
DDS worker	_____	_____
DCF worker	_____	_____

(☐Voluntary ☐Investigations ☐Ongoing services)

Covid-19 Precautions

☐ COVID-19 exposure screening

Will child wear a mask for program hours? ☐Y ☐N

Decision Point:

A) Appropriate for PHP admission: ☐Y ☐N Date reviewed with Medical Director: _____

Date of intake assessment: _____ Wait time quoted to referral source: _____

B) Needs higher level of care: ☐Referral to AIU ☐Referral to ED ☐Referral to other hospital

C) Not appropriate for PHP admission: State reason: _____

Referral made (date and type of service): _____

Form completed by:_____
(print name/title)