hfsc Hospital for Special Care | We rebuild lives.

Submit all documents to:
Autism Admissions
Coordinator: Kayla Santiago
Ksantiago@hfsc.org
P: 860-827-4841
F: 860-832-6273

Hospital for Special Care Autism Inpatient Unit Referral Form

Date: _____

Patient's Demographic Information

Patient's Name:	Date of Birth:	Age:
Address:		
Preferred Name:	Preferred Pronouns:	Gender assigned at birth: ☐ Male ☐ Female
Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Other _____ ☐ Choose not to disclose	Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Don't know ☐ Other _____ ☐ Choose not to disclose	
Race: ☐ Black/African American ☐ White ☐ Asian ☐ Asian Indian ☐ Other Pacific Islander ☐ American Indian ☐ Other:_____ ☐ Choose not to disclose		
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Puerto Rican ☐ Cuban ☐ Mexican/Mexican American ☐ Other:_____ ☐ Choose not to disclose		
Patient Primary Language:	Parent Primary Language:	
Height:	Weight:	Patient is: ☐ Verbal ☐ Nonverbal
Primary Contact:	Relationship to Child:	
Phone:	Cell:	Email:
Secondary Contact:	Relationship to Child:	
Phone:	Cell:	Email:
Custody Arrangement: ☐ Mother ☐ Father ☐ Joint ☐ Other Guardian _____ If 18 or older, is the patient conserved: ☐ Yes ☐ No _____		
DCF Involvement: ☐ No ☐ Yes ☐ Voluntary ☐ Past Involvement (please specify)_____		
DDS Involvement: ☐ No ☐ Yes (If yes, contact information)_____		

Insurance Information:

Please attach a copy of the insurance card

Primary Insurance:	ID#:	
Subscriber Name:	Relationship:	DOB:
Subscriber Phone:	Subscriber Address:	
Secondary Insurance:	ID#:	
Subscriber Name:	Relationship:	DOB:
Subscriber Phone:	Subscriber Address:	

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Referral Information: (Please note all referrals must come from an MD)
Referring MD: _____ Specialty:_____
Facility: _____
Phone #:_____ Fax #: _____
Diagnosis: _____

Autism Diagnostic Evaluation (Note: Must attach written report of evaluation by a Psychologist or MD, outside of school, who used one of the following tests to diagnose Autism: CARS, GARS, or ADOS)

Reason for Referral:

Problem Behaviors (Please include duration, Frequency and day 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:

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Patient's Current Medications:

Medication	Schedule	Prescribing MD

Please list any known drug or environmental allergies or sensitivities:

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, AFOs):

_____ _____ _____

Signature **Print Name** **Date**

Please provide the following with your referral:

- ☐ Insurance card(s) front & back
- ☐ Parent/Guardian Questionnaire Form
- ☐ ASD Testing
- ☐ Pertinent Office Notes/Lab Results
- ☐ Educational Testing and latest IEP
- ☐ Current Medication list
- ☐ Copy of Legal Guardian or Conservator document if patient is 18+ years of age