



Hospital for Special Care Autism Inpatient Unit  
Referral Form

Date: \_\_\_\_\_ (Please note all referrals must come from an MD)

Patient's Demographic Information

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



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)

[Empty box for Autism Diagnostic Evaluation report]

Reason for Referral:

[Empty box for 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

[Empty box for Problem Behaviors description]

Safety Concerns:

[Empty box for Safety Concerns]

Current Services (Respite, in-home ABA, etc):

[Empty box for Current Services]

Anticipated goals of program and discharge plan:

[Empty box for Anticipated goals of program and discharge plan]



Patient's Current Medications:

Table with 3 columns: Medication, Schedule, Prescribing MD. Contains 5 empty rows for data entry.

Please list any known drug or environmental allergies or sensitivities:

Large empty rectangular box for listing allergies or sensitivities.

Current Diet and Food Allergies [ ] No Known Food Allergies

Large empty rectangular box for detailing current diet and 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):

Large empty rectangular box for describing medical diagnoses and equipment needs.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Please provide the following with your referral:

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