hfsc Hospital for Special Care

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

hfsc Hospital for Special Care

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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:** _____

www.hfsc.org
2150 Corbin Avenue, New Britain, CT 06053

THE AUTISM CENTER
Phone: 860-612-6381 / Fax: 860-392-6450

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