Provider Referral Form (Clinic)
Center for Autism and Developmental Disorders

Referral Source Information

Referring Provider ______________________________ Agency ___________________________________

Address____

Phone #_____________________________ Fax # _____________________________________

Date of Referral _____________________ Completed by _____________________________

Patient Information

Name____ DOB____________________ Age________

Guardian's Name________________________________

Guardian's Address____

Phone # _________________________________

Primary Language Spoken _______________________ Interpreter Needed □ Yes □ No

Insurance Information

Primary ____

Secondary ____

Has this child been diagnosed with Autism Spectrum Disorder or Intellectual Disability, either by you or by another provider? □ Yes □ No

Reason for Referral

Presenting Problem - Please check all that apply – (Circle your #1)

□ Anxiety □ Tantrums □ Self-Injurious Behavior □ Family Issues
□ Depression □ Grief/Loss □ Motor Concerns □ Aggression
□ Regression □ Sensory Concerns □ Mood Dysregulation
□ Speech/Communication Concerns □ Developmental Concerns
□ Other: ____

Please briefly describe the reason you are referring this patient to our clinic.

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What services do you feel this patient needs?

□ Individual Therapy for Child □ Family Therapy
□ Medication Management (Psychiatry) □ Behavioral Treatment
□ Social Skills Group □ Case Management
□ Other _________________________________

Is the family aware of this referral? □ Yes □ No
May we contact the family? □ Yes □ No

****Please include your first and last progress notes, a treatment summary (if available), and any neuropsychological testing with this referral. Please note that the patient's guardian will need to complete the Patient Information Packet (available on our website) prior to making an appointment.**

Thank you for your referral! We will contact you if we have questions.