

Date: _____

ATTENTION: PLEASE ATTACH SPECIFIC DETAILS AND/OR RECORDS REGARDING THE CHILD'S SYMPTOMS/CONCERNS OR THE REFERRAL MAY BE RETURNED

Reason for Referral:

- Autism Testing
- Intellectual Disability (ID) Testing
- One-time behavioral consult for a child with autism, ID, and/or global developmental delay
 - What specific behavior and when/where is it happening (e.g., child is aggressive during morning routine)?: _____

Please list specific concerns for this child (this section must be completed):

Symptoms/Concerns (check all that apply):

Autism-related concerns? Yes / No

- Peer difficulties
- Limited social communication (e.g., back-and-forth interaction)
- Repetitive behaviors/intensive interests

Other concerns? Yes / No

- Intellectual disability
- Developmental delay
- Speech/Language
- Attention/Hyperactivity
- Aggression
- Self-injurious behavior

Mood lability (e.g., irritability)

Anxiety/Fears

In utero substance exposure

Tics/OCD

Other: _____

PATIENT: _____ **DOB:** _____ **M** **F**
(First) (MI) (Last)

ADDRESS: _____

PRIMARY PHONE NUMBER: _____

Parent/Guardian: Name: _____ DOB: _____
(W) _____ (Cell) _____

Parent/Guardian: Name: _____ DOB: _____
(W) _____ (Cell) _____

INSURANCE INFORMATION: Please include copy of front and back of insurance card(s)

Primary Insurance: _____ Subscriber: _____ DOB: _____
Group #: _____ Policy #: _____

Secondary Insurance: _____ Subscriber: _____ DOB: _____
Group #: _____ Policy #: _____

Medicaid #: _____ Assigned MCO: _____

REFERRING PHYSICIAN: _____

Address: _____ Phone: _____ Fax: _____

INTERPRETER NEEDED? YES NO Preferred Language: _____

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