# AUTISM ASSESSMENT PROGRAM
## REFERRAL REQUEST

PHONE: 802-847-4563  FAX: 802-847-7998

Our program only accepts referrals from primary care providers. Please note the following:

- There must be a documented concern for autism spectrum disorder.
- We accept referrals for children through 7 years, 11 months of age.
- We do not accept referrals for repeat or “follow up” evaluation.
- Patients must reside in the state of Vermont.
- We require receipt of certain materials before the patient is added to our waiting list, including: clinic paperwork; past psychological and/or developmental evaluation reports; Early Intervention records; school evaluation records (recent and past); and current Individualized Education Program (IEP).
- The evaluation will be billed under medical or mental health insurance, and families could incur significant out of pocket costs. Please advise families to check their child's insurance coverage.

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Child's Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child's DOB:</td>
<td>Primary Language:</td>
</tr>
<tr>
<td></td>
<td>Interpreter Needed:</td>
</tr>
</tbody>
</table>

### PRIMARY CARE PROVIDER

<table>
<thead>
<tr>
<th>Name:</th>
<th>Practice:</th>
<th>Phone:</th>
<th>Fax:</th>
</tr>
</thead>
</table>

### PARENTS/GUARDIANS (If child is in DCF custody, then list caseworker as primary contact)

<table>
<thead>
<tr>
<th>PRIMARY CONTACT</th>
<th>SECONDARY CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>Mailing Address:</td>
</tr>
<tr>
<td>Primary Phone:</td>
<td>Primary Phone:</td>
</tr>
<tr>
<td>2nd Phone:</td>
<td>2nd Phone:</td>
</tr>
<tr>
<td>Email:</td>
<td>Email:</td>
</tr>
</tbody>
</table>

### INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Insurance Carrier:</th>
<th>Subscriber Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group #:</td>
<td>ID #:</td>
</tr>
</tbody>
</table>

Form#DOC0010532 (08/2023)  Scan to Referral Forms Page 1 of 2
PLEASE SELECT ALL DIAGNOSES THE CHILD HAS BEEN GIVEN

- Autism Spectrum Disorder (ASD)
- Global Developmental Delay
- Intellectual Disability
- Speech/Language Disorder
- Motor Skills Delay/Disorder
- Learning Disability
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Oppositional Defiant Disorder (ODD)
- Depressive Disorder
- Anxiety Disorder
- Obsessive Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Reactive Attachment Disorder (RAD)
- Other: ____________________

DESCRIBE NEED FOR AUTISM EVALUATION, INCLUDING SYMPTOMS AND CONCERNS

PLEASE SELECT ALL SERVICES AND/OR THERAPIES THE CHILD IS CURRENTLY RECEIVING (This section MUST be completed or referral will be declined – please select all that apply)

- CIS/Early Intervention
- Speech/Language Therapy (SLP)
- Occupational Therapy (OT)
- Physical Therapy (PT)
- Individualized Education Program (IEP)
- Mental Health Supports, Counseling
- Child Psychiatry/Medication Management
- PCIT (Parent Child Interaction Therapy)
- Other:
- None

Referring Provider Signature: _______________________________ Date/Time: _______________________________

Printed Name: _______________________________

PLEASE FAX THIS COMPLETED FORM AND PERTINENT RECORDS TO: 802-847-7998, ATTENTION INTAKE. THANK YOU.