THE University of Vermont MEDICAL CENTER

Autism Assessment Clinic
Referral Request

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

Thank you for your referral to the Vermont Center for Children Youth and Families and the Autism Assessment Clinic. This clinic only provides autism assessments for Vermont Medicaid supported families in partnership with the Vermont Department of Health.

Please complete and fax the following form to facilitate scheduling your patient's consultation with the program. Please include any relevant material for this evaluation, including **lab and radiology reports, therapy evaluations, school evaluations, psychology assessments, and Individual Education Plans (IEPs).**

DEMOGRAPHICS:

Child's Name:	Youth's gender identification: ☐ M ☐ F ☐ Transgender ☐ Other _____ **Biological sex**: ☐ M ☐ F
Date of Birth: Age:	MRN# *(office use only)*

Parent/ Guardian #1(circle one):	DOB:
Address: City: State: Zip:	
Phone:	
Email:	

Parent/ Guardian #2 (circle one):	DOB:
Address: City: State: Zip:	
Phone:	
Email:	

INSURANCE INFORMATION (Program currently only accepts patients with VT Medicaid):

Primary Insurance:	
ID Number:	

Secondary Insurance:	
ID Number:	

Medicaid: Yes ☐ No ☐	

Autism Assessment Program Referral Request

PRIOR & CURRENT EVALUATIONS & SERVICES:	**PLACE OF SERVICE & PHONE NUMBER**
ə Occupational Therapy	
ə Physical Therapy	
ə Speech Therapy	
ə Hearing Test	
ə School / Psychology Testing	
ə IEP / Special Ed. Services	
ə Other Specialty Evaluations	
ə Pertinent lab results	
ə Pertinent radiology results	
ə **CURRENT MEDICATIONS**	

KNOWN DIAGNOSES	**REASON FOR REFERRAL** **(This is a diagnostic program; we are unable to provide ongoing treatment services)**
ə Genetic Disorder: _____ ə Metabolic Disorder: _____ ə Developmental Delay ə Gross Motor Delay ə Fine Motor Delay ə Speech Delay ə Autism Spectrum Disorder ə Intellectual Disability ə ADHD ə Emotional / Behavioral Disorder ə Learning Disability ə Cerebral Palsy ə Other: _____	*Please describe why you suspect that the child may have an ASD. We would like details regarding behaviors, communication difficulties, language skills, and social interaction deficits. Please be specific. What tools have been used to screen for ASD (e.g. MCHAT)?*

PRIMARY CARE PROVIDER:	**REFERRING PROVIDER:**
Name:	Name:
Practice:	Practice:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

If you have any questions, please call 802-847-4563.
Please fax this form and any relevant documents to 802-847-7998