Autism Evaluation Referral Form

Referring Provider ____ Date _________________

Primary Care Physician ____

Child's Name _____________________________________ Gender ❑ M ❑ F DOB ____________

Parent/Guardian's Name(s) ____

Address ____

Home Phone _____________________________________ Cell Phone _______________________

Signature of Parent/Guardian ____ Date ___________

Relationship to Child ____

Reason for Referral (please check all that apply)

❑ Screening results (please include a copy)

❑ M-CHAT-R™ (16-30 months) *or* ❑ ASQ: SE

❑ Parent concern ____

❑ Other observations and/or areas of concern ___________________________________

____

Greenbush Autism Diagnostic Team Response

Screened by ____ Date of Screening ____________

The following is a summary of the status of the referral.

❑ The child was screened and does not meet criteria for a diagnostic assessment.

❑ The child was screened and a further diagnostic evaluation is recommended. The evaluation has been scheduled on ________ .

❑ Repeated attempts have been made to contact this family. Please let us know if the contact information for the family has changed.

❑ The parent did not consent to have his/her child evaluated.

❑ The child has been screened/evaluated, however, the family declined to sign a consent authorizing the Greenbush Autism Diagnostic Team to share information with your practice/agency.

❑ The child was screened by their physician and meets criteria for a diagnostic evaluation. This evaluation is scheduled on ___________ .

❑ Other ____