Hospital *for* Special Care

We Rebuild Lives.

The Autism Center at Hospital for Special Care Clinician Referral Form

Date _____

Referring Physician Name	NPI #	Phone/Fax #

PCP Name	Phone/Fax #

Patient Information

Patient Name _____ DOB ____/____/____ Age _____

Patient Phone # Home _____ Cell _____

Address _____

Emergency Contact _____ Phone # _____ Relationship _____

Email _____ Primary Language _____

Interpreter Needed? ☐ Yes ☐ No **child must understand English*

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Race ☐ American Indian ☐ Asian/Pacific Islander ☐ African American ☐ Hispanic
☐ Caucasian ☐ White ☐ Other _____

Type of Referral

☐ Psychiatry/Medication Management
☐ Psychological Testing *(prescription required**)*
☐ Dev Peds-only for question of ASD or 2nd opinion - ages 2-5 years old
☐ Family Therapist
☐ Occupational Therapy *(prescription required**)*
☐ Speech Therapy *(prescription required**)*
☐ eating/feeding ☐ expressive-receptive language ☐ Augmentative Alternative Communication (AAC) ☐ social language

Degree of Urgency: ☐ Routine ☐ Urgent (recent hospitalization/ED visit) ☐ Priority: 1st Birthday to 3 years of age

Reason for Referral ***REQUIRED*** *referral will not be processed if this section not completed* _____

Date of last Physical Exam ____/____/____ Current Diagnosis _____

Current Medications _____

Relevant Background *(check all that apply)*

☐ delayed speech and language ☐ avoids eye contact ☐ does not point or respond to pointing
☐ lines up toys or other objects ☐ does not respond to their name ☐ ignores minor injuries
☐ does not point at objects to show interest ☐ gets upset by minor changes ☐ does not play "pretend" games ("feed" a doll)
☐ has obsessive interests/routines ☐ overreacts to certain sounds ☐ licks non-food items
☐ smells things w/o obvious odors ☐ plays with toys the same way each time

Phone 860.612.6380 / Fax 860.612.6384

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Insurance Information

Primary Insurance _____ ID # _____

Guarantor _____ Relationship _____ DOB ___/___/___

Secondary Insurance _____ ID # _____

Required Documents/Information

Information REQUIRED from referring clinician for release of appointment date

- **MD Order for Psychological Testing, Speech &/or OT(can be written on a prescription pad)
- Pertinent Office Notes/Specialist & Consult Notes/ Most current lab results

Please inform parent/guardian that receipt of the following documentation is required for release of an appointment date

- For children under the age of 5y/o: M-CHAT, most recent B-3 consult note, current IEP/504 (if applicable)
- For children over the age of 5y/o: previous psychological and/or educational testing & current IEP/504 (if applicable)

Parent/Caregiver Primary Concern _____

History/Records Information

School _____

Other Services _____

Has child ever had psychological testing before? ☐ *Yes ☐ No **must be submitted for release of appointment date*

If yes, when & where _____

PLEASE FAX REQUIRED INFORMATION ALONG WITH THIS REFERRAL FORM TO 860-612-6384

Referred by _____ Phone _____ Fax _____

☐ Self-Referred (parent)

Please let us know how you heard of us: ☐ Print ☐ Website ☐ Connection ☐ Other _____

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12.2017