

Agency/Professional Referral Questionnaire for Adult Client (age 18 and older)

Required information: To refer an adult to TEACCH Autism Program, the referring professional needs to complete this form.

IDENTIFYING CLIENT INFORMATION-----

Client Name: _____ Date: _____

Date of Birth: _____ Gender: Male Female

Parent/Guardian Name: _____

Phone: _____ Email: _____

Street or Mailing Address: _____ Suite or Apt #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Is client his/her own guardian? Yes No

In North Carolina, all persons over 18 years of age who have not had their rights to manage their money and medical care legally transferred to someone else by a judge are their own guardians.

REFERRING PROFESSIONAL INFORMATION-----

Referring Professional's Name: _____

Agency: _____

Position:

Physician Nurse Psychiatrist Social Worker Occupational therapist

Teacher/other school personnel Counselor/Therapist Speech Language Pathologist Mental Health worker

Other (please specify): _____

Street or Mailing Address: _____ Suite or Apt #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Email: _____

Primary Phone: _____ Fax: _____

ADULT REFERRAL INFORMATION-----

How long have you known this client?

In what capacity?

Services Requested/Recommended – please select one

Client needs a Diagnostic Evaluation for Autism Spectrum Disorder

Client has a confirmed ASD diagnosis and needs Treatment Services and Family Education

EXISTING DIAGNOSES

Please list all existing diagnoses and provide any documentation and diagnostic reports that you have.

REASON FOR REFERRAL

Please describe behaviors in the sections below that are areas of concern that you feel warrant TEACCH Services. If referring for a diagnostic evaluation, list symptoms and concerns **not** accounted for by the client's current diagnoses. Please be specific.

Social and Emotional Relatedness

Communication / Receptive Language / Expressive Language

Restricted Interests and Repetitive Behaviors *(include unusual preoccupations, rituals, routines, or sensory interests).*

Other

What is this client's understanding of this referral and the services offered by the TEACCH Autism Program?

What personal and professional supports or resources does this client currently have? To what extent are these supports helpful and adequate?

Please add anything else that you think we should know about this client.

Person completing this Adult Referral Questionnaire: _____

Thank you for completing this form.

Please enclose relevant reports from services you provided or evaluations you completed (psychological, medical, educational, language, treatment summaries, other).

Please mail or fax to the following address:

GREENSBORO TEACCH CENTER
925 Revolution Mill Drive, Suite 7
Greensboro, NC 27405
T: (336) 334-5773 F: (336) 334-5811