

## 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:*

**ASHEVILLE TEACCH CENTER**  
100 Technology Drive, Suite A  
Asheville, NC 28803  
T: (828) 251-6319 F: (828) 251-6358