

## Agency/Professional Referral Questionnaire for Child or Adolescent (through age 17)

*\*Required Information: To refer a child/adolescent 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: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Street or Mailing Address: \_\_\_\_\_ Suite or Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

### REFERRING PROFESSIONAL INFORMATION -----

Referring Professional's Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Position:

- |                     |                             |                                |                                |
|---------------------|-----------------------------|--------------------------------|--------------------------------|
| Physician           | Nurse                       | Psychiatrist                   | Psychologist                   |
| Social Worker       | Occupational therapist      | Teacher/other school personnel | Other <i>(please specify):</i> |
| Counselor/Therapist | Speech Language Pathologist | Mental Health Worker           |                                |

Street or Mailing Address: \_\_\_\_\_ Suite or Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**CHILD/ADOLESCENT REFERRAL INFORMATION** -----

How long have you known this child?

In what capacity?

**Services Requested/Recommended – *please select one***

Child needs a Diagnostic Evaluation for Autism Spectrum Disorder

Child has a confirmed ASD diagnosis and needs Treatment Services and Parent 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 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

**INFORMATION ABOUT THE FAMILY** -----

Does the family know about TEACCH and are they aware of the reason for this referral?

Please add anything else that you think we should know about this child and/or family (*e.g language spoken in the home*).

Person completing this 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 fax or mail to the following address:*

**CHAPEL HILL TEACCH CENTER**  
CB# 6305 UNC-Chapel Hill  
Chapel Hill, NC 27599  
T: (919) 966-5156 Fax: (919) 966-4003