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 (*please specify*):
☐ 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:

WILMINGTON TEACCH CENTER
1099 Medical Center Drive, Suite 102
Wilmington, NC 28401
T: (919) 445-0680 Fax: (919) 445-0691