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							
Date:							
Client Name:				**Date of Birth:**			
Parent/Guardian Name:							
Phone Number:		**Email:**					
Mailing Address:							
City:		**State:**		**Zip Code:**		**County:**	
Is the 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.							
IDENTIFYING 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):						
Phone Number:		**Fax Number:**					
Mailing Address:							
City:		**State:**		**Zip Code:**		**County:**	
Email:							

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:

Wilmington TEACCH Center – 1099 Medical Center Drive, Suite 102 Wilmington, NC 28401

T: 919-445-0680 F: 919-445-0691