# 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.*

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| **IDENTIFYING CLIENT INFORMATION** | | | | | | | | | | **Date:** | |
| **Client Name:** | | | | | | | | | | **Date of Birth:** | |
| **Parent/Guardian Name:** | | | | | | | | | | | |
| **Phone Number:** | | | | | | **Email:** | | | | | |
| **Mailing Address:** | | | | | | | | | | | |
| **City:** | | **State:** | | **Zip Code:** | | **County:** | | | | | |
| **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 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 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 child'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:** |
|---|
| |
| **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 home).** |
| |

| **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: 919-966-1000 F: 919-445-2354**