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							**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:

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

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