Agency/Professional Referral Questionnaire for Client

Required information: *To refer a client to the TEACCH Autism Program, the referring professional needs to complete this form.*

IDENTIFYING CLIENT INFORMATION								**Date:**	
Client Name:								**Date of Birth:**	
Phone Number:				**Email:**					
Mailing Address:									
City:		**State:**		**Zip Code:**		**County:**			
Is the client their 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.*				
If no, or client under 18	**Parent/Guardian Name:**								
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:									

CLIENT 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 and/or family'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 and/or family.

Person completing this Client 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 send to the local TEACCH Center.