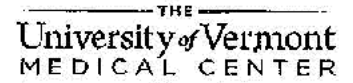


<input type="checkbox"/> INITIAL <input type="checkbox"/> FOLLOW-UP	REFERRAL DATE:
<input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED	LAST EVALUATION:



PHONE: 802-847-2007 FAX: 802-847-3358



**DEVELOPMENTAL PEDIATRICS & AUTISM ASSESSMENT REFERRAL REQUEST**

UVM DEVELOPMENTAL &  
BEHAVIORAL PEDIATRICS

VCCYF AUTISM  
ASSESSMENT CLINIC

<b>REFERRAL SOURCE</b>	<b>PRIMARY CARE PROVIDER (if different)</b>
NAME:	PCP NAME:
AFFILIATION:	PRACTICE:
PHONE:	PHONE:
FAX:	FAX:

**WHO INITIATED REQUEST:**     PARENT     SCHOOL     PCP     MEDICAL SPECIALIST     OTHER:

**CHILD'S NAME:**

DOB:                      AGE:                      GENDER ID: \_\_\_\_\_                      BIOLOGICAL SEX:  MALE     FEMALE

**INSURANCE**

VT MEDICAID     YES     NO    UNI:

PRIVATE INSURANCE:  BC/BS     MVP     CIGNA     HARVARD PILGRIM     TRICARE     OTHER:

GROUP #:    ID#:    INSURED PERSON:

**PARENTS/GUARDIANS: (NOTE: IF IN DCF CUSTODY LIST CASEWORKER AS PRIMARY CONTACT)**

<b>PRIMARY PARENT/GUARDIAN</b>	<b>SECONDARY PARENT/GUARDIAN</b>
NAME:	NAME:
RELATIONSHIP:	RELATIONSHIP:
MAILING ADDRESS:	MAILING ADDRESS:
CITY:                                      STATE:                      ZIP:	CITY:                                      STATE:                      ZIP:
PRIMARY PHONE:	PRIMARY PHONE:
2 <sup>ND</sup> PHONE:	2 <sup>ND</sup> PHONE:
WORK PHONE (IF OK TO CALL):	WORK PHONE (IF OK TO CALL):
EMAIL: * (REQUIRED FOR TELEMEDICINE OPTION BELOW) *	EMAIL:

**REASON FOR REFERRAL** (These are diagnostic programs; we are unable to provide ongoing treatment services.)

AUTISM     INTELLECTUAL DISABILITY     COGNITIVE/LD                       BEHAVIOR

DEVELOPMENTAL DELAY(S) (check all that apply BELOW)

GLOBAL     SPEECH/LANGUAGE, COMMUNICATION     FINE MOTOR     GROSS MOTOR     SOCIAL-EMOTIONAL     ADAPTIVE

PLEASE DESCRIBE PRIMARY QUESTION/CONCERN & WHAT YOU WANT FROM EVALUATION:

**CONTINUED: CHILD'S NAME:**

WHY IS ASD OR DEVELOPMENTAL DISABILITY SUSPECTED?

**KNOWN DIAGNOSES:**

MEDICAL CONDITIONS AFFECTING DEVELOPMENT (I.E. GENETIC, METABOLIC, NEUROLOGICAL DISORDERS, PREMATURITY, CP)

CURRENT MEDICATIONS:

PRESCRIBER:

**ASSISTANCE REQUIRED:**

INTERPRETER NEEDED?  YES  NO FOR:  CHILD  PARENT LANGUAGE:

HEARING ASSISTANCE?  YES  NO (ASL interpreter, special equipment, etc.)

ASSISTANCE COMPLETING PAPERWORK?  YES  NO

**TELEMEDICINE SCREENING:**

ARE THERE BARRIERS TO ATTENDING AN OFFICE APPOINTMENT?  YES  NO (travel, childcare, work, etc.)

IS THERE INTEREST IN TELEMEDICINE AS AN OPTION?  YES  NO

**\*(IF YES, REVIEW DETAILED TELEMEDICINE SCREENING; REQUEST CONSENT) \***

**SERVICES, PROVIDERS & EVALUATIONS:** (IF AN EVALUATION WAS DONE PLEASE PROVIDE ALL RESULTS/REPORTS)

BIRTH TO THREE (CIS-Early Intervention)

PRESCHOOL (ECSE, HEADSTART, PRIVATE)

DEVELOPMENTAL SERVICES

IEP/SPECIAL ED/504

VCCYF AUTISM CLINIC  CDC

DARTMOUTH CDP

NEUROLOGY

COUNSELING/MENTAL HEALTH SUPPORT/PSYCHIATRY

AUDIOLOGY/HEARING

GENETICS

OT/PT/SLP

VISION/VABVI

MCHAT

IQ TESTING/ COGN.

SSI/DCHC

PCA

OTHER: \_\_\_\_\_

**ADDITIONAL NOTES:**

**ONCE COMPLETED PLEASE FAX THIS FORM AND PERTINENT RECORDS  
TO, 802-847-3358, ATTENTION CENTRAL INTAKE. THANK YOU.**