❒ INITIAL ❒ FOLLOW-UP	REFERRAL DATE:
❒ ACCEPTED ❒ DECLINED	LAST EVALUATION:

VERMONT Department of Health

THE University of Vermont MEDICAL CENTER

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

DEVELOPMENTAL PEDIATRICS & AUTISM ASSESSMENT REFERRAL REQUEST

UVM DEVELOPMENTAL & BEHAVIORAL PEDIATRICS

VCCYF AUTISM ASSESSMENT CLINIC

REFERRAL SOURCE	**PRIMARY CARE PROVIDER (if different)**
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)

PRIMARY PARENT/GUARDIAN			SECONDARY PARENT/GUARDIAN		
NAME:			NAME:		
RELATIONSHIP:			RELATIONSHIP:		
MAILING ADDRESS:			MAILING ADDRESS:		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
PRIMARY PHONE:			PRIMARY PHONE:		
2ND PHONE:			2ND 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.