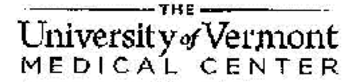
❐ INITIAL	❐ FOLLOW-UP	REFERRAL DATE:
❐ ACCEPTED	❐ DECLINED	LAST EVALUATION:



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

DEVELOPMENTAL PEDIATRICS & AUTISM ASSESSMENT REFERRAL REQUEST

CHILD DEVELOPMENT CLINIC BARRE & RUTLAND	UVMMC DEVELOPMENTAL BEHAVIORAL PEDIATRICS	VCCYF AUTISM ASSESSMENT CLINIC

REFERRAL SOURCE	**PRIMARY CARE PROVIDER (if different)**
NAME:	PCP NAME:
AFFILIATION:	PRACTICE:
PHONE:	PHONE:
FAX:	FAX:

CHILD'S INFORMATION		
NAME:		NICKNAME:
DOB:	AGE:	GENDER ID:
RESIDENCE: STATE:		TOWN:

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:

WHY IS ASD OR DEVELOPMENTAL DISABILITY SUSPECTED?

WHAT DO YOU EXPECT TO GET FROM THIS EVALUATION?

WHO INITIATED THIS REQUEST (I.E. PARENT, SCHOOL, DOCTOR)?

KNOWN DIAGNOSES:

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

CURRENT MEDICATIONS:

PRESCRIBER:

CONTINUED: CHILD'S NAME:

PREVIOUS EVALUATIONS & SCREENINGS: (PLEASE PROVIDE ALL RESULTS/REPORTS)

❒ VCCYF AUTISM CLINIC	❒ NICU FOLLOW-UP	❒ IQ TESTING/ COGN.	❒ MCHAT
❒ CDC	❒ DARTMOUTH CDP	❒ SPECIAL ED	❒ CIS-EARLY INTERVENTION
❒ OT/PT/SLP	❒ AUDIOLOGY	❒ GENETICS	❒ NEUROLOGY

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:		

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) ***

INSURANCE:

VT MEDICAID ❒ YES ❒ NO		UNI:
PRIVATE INSURANCE:		
❒ BC/BS	❒ MVP	❒ CIGNA
❒ HARVARD PILGRIM	❒ TRICARE	❒ OTHER:
GROUP #:	ID#:	INSURED PERSON:

SERVICES/PROVIDERS:

❒ BIRTH TO THREE (CIS-Early Intervention)	❒ PRESCHOOL (ECSE, HEADSTART, PRIVATE)
❒ IEP/SPECIAL ED/504	❒ OCCUPATIONAL THERAPY
❒ PHYSICAL THERAPY	❒ SPEECH THERAPY
❒ COUNSELING/MENTAL HEALTH SUPPORT	❒ PSYCHIATRY
❒ AUDIOLOGY/HEARING	❒ VISION/VABVI
❒ DEVELOPMENTAL SERVICES	❒ PCA
❒ SSI/DCHC	❒ OTHER: ___________________________________

ADDITIONAL NOTES:

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