THE University of Vermont Children's Hospital

**AUTISM ASSESSMENT PROGRAM**
**REFERRAL REQUEST**

**PHONE: 802-847-4563 FAX: 802-847-7998**

**Our program only accepts referrals from primary care providers. Please note the following.**

- There must be a documented concern for autism spectrum disorder.
- We accept referrals for children through 7 years, 11 months of age.
- We do not accept referrals for repeat or "follow up" evaluation.
- Patients must reside in the state of Vermont.
- We require receipt of certain materials before the patient is added to our waiting list, including: clinic paperwork; past psychological and/or developmental evaluation reports; Early Intervention records; school evaluation records (recent and past); and current Individualized Education Program (IEP).
- The evaluation will be billed under medical or mental health insurance, and families could incur significant out of pocket costs. **Please advise families to check their child's insurance coverage.**

| | |
|---|---|
| Child's Name: | |
| Child's DOB: | Child's Gender: |
| Primary Language: | Interpreter Needed: |
| **PRIMARY CARE PROVIDER** | |
| Name: | |
| Practice: | |
| Phone: | |
| Fax: | |
| **PARENTS/GUARDIANS** (***If child is in DCF custody, then list caseworker as primary contact)*** | |
| PRIMARY CONTACT | SECONDARY CONTACT |
| Name: | Name: |
| Relationship: | Relationship: |
| Mailing Address: | Mailing Address: |
| Primary Phone: | Primary Phone: |
| 2nd Phone: | 2nd Phone: |
| Email: | Email: |
| **INSURANCE INFORMATION** | |
| Insurance Carrier: | Subscriber Name: |
| Group #: | ID #: |

**PLEASE SELECT ALL DIAGNOSES THE CHILD HAS BEEN GIVEN**

- ☐ Autism Spectrum Disorder (ASD)
- ☐ Global Developmental Delay
- ☐ Intellectual Disability
- ☐ Speech/Language Disorder
- ☐ Motor Skills Delay/Disorder
- ☐ Learning Disability
- ☐ Attention-Deficit/Hyperactivity Disorder (ADHD)
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Depressive Disorder
- ☐ Anxiety Disorder
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Reactive Attachment Disorder (RAD)
- ☐ Other: _____

| **DESCRIBE NEED FOR AUTISM EVALUATION, INCLUDING SYMPTOMS AND CONCERNS** |
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| |

| **PLEASE SELECT ALL SERVICES AND/OR THERAPIES THE CHILD IS CURRENTLY RECEIVING *(This section MUST be completed or referral will be declined – please select all that apply)*** | |
|---|---|
| ☐ CIS/Early Intervention | ☐ Mental Health Supports, Counseling |
| ☐ Speech/Language Therapy (SLP) | ☐ Child Psychiatry/Medication Management |
| ☐ Occupational Therapy (OT) | ☐ PCIT (Parent Child Interaction Therapy) |
| ☐ Physical Therapy (PT) | ☐ Other: |
| ☐ Individualized Education Program (IEP) | |
| ☐ 504 Plan | ☐ None |

Referring Provider Signature: _____ Date/Time: _____

Printed Name: _____

**PLEASE FAX THIS COMPLETED FORM AND PERTINENT RECORDS TO: 802-847-7998, ATTENTION INTAKE. THANK YOU.**