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.
- We are limiting referrals for second opinion requests, especially when the child has been evaluated in the past year. These are considered on a case-by-case basis.
- 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

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.