

PROGRAM REFERRAL

Check all that apply:

- Autism Center (children must have a confirmed autism diagnosis to receive ABA services)
- Autism-Focused Diagnostic Evaluation
- Early Intervention (must reside in the Alpine School District)
- Early Head Start

REFERRING PROVIDER

Provider Name: _____ Clinic / Organization: _____

Phone: _____ Fax: _____ Email: _____

CHILD INFORMATION

Child's First Name: _____ Last Name: _____

Gender: Male Female Date of Birth: _____Has the child received an official diagnosis? Yes No

If yes, please briefly summarize diagnosis: _____

PARENT / GUARDIAN INFORMATION

Guardian First Name: _____ Last Name: _____

Phone Number: _____ Email: _____

Mailing Address (Street, City, State, ZIP): _____

REFERRAL CONCERNS & CLINICAL NOTES

Briefly describe your primary concerns and reason for referral: _____

DOCUMENTS INCLUDED (OPTIONAL)

- Diagnostic report Pediatrician notes Previous evaluations School / IEP report
- Developmental history Therapy reports (OT/PT/SLP/ABA) Copy of insurance card
- Other: _____

INSURANCE INFORMATION (OPTIONAL)

Insurance Provider: _____ Policy Holder Name: _____

Member ID: _____ Group #: _____