Referral Request Form

Office Phone: 949-267-0400 Intake Coordinator: 949-267-0447 Fax: 949-221-0004

Thank you for your referral to The Center for Autism & Neurodevelopmental Disorders.

Patient Information

Does the patient live with someone other than the legal guardian? □ No □ Yes, relationship____________

Patient name:_____________________________ Date of Birth: ______/______/______

Has a diagnosis of Autism Spectrum Disorder been provided at any point: □ Yes □ No

Other Diagnosis: ____ Dx Provided by: ______________________

Parent/Guardian:__________________________ Parent Phone: _______________________

Insurance:_________________________________ Parent Cell: _________________________

1. **What is the patient's current chief complaint?**

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2. **Primary purpose of referral. Please select from the following:**

□ ABA/behavioral therapy
□ Counseling
□ Speech & language therapy
□ Occupational therapy
□ Medication management
□ Educational assessment or school consultation
□ Parent training
□ Resource guidance
□ Diagnosis
□ Re-evaluation of diagnosis
□ Other:_________________________________

To expedite appointment scheduling, please provide the following by FAX 949-221-0004:
□ This completed form
□ Medical records related to the chief complaint
□ Authorization, or if not applicable a copy of insurance card

Primary Pediatrician Name: ______________________________ Phone:___________ Fax:__________

Referring Provider Name: ______________________________ Phone:___________ Fax:__________

Provider Signature: ______________________________________ Date:____________