THE CENTER FOR **AUTISM**
**& NEURODEVELOPMENTAL DISORDERS**

2500 Red Hill Ave, Ste 100 Santa Ana, CA 92705
t: 949.267.0400
f: 949.221.0004 www.thecenter4autism.org

# Referral Request Form

**Intake Coordinator Phone: 949-267-0447** Intake Fax: 949-221-0004

**Patient Information**

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

Patient Name: ________________________________ Date of Birth: ________/________/__________

Diagnosis: ____________________________________________________________________________________

Parent/Guardian: ______________________________ Parent Phone: ____________________________

Insurance: ____________________________________ Parent Cell: _______________________________

Family's Primary Spoken Language: ________________________ Parent Email: ______________________________

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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

□ Diagnostic medical consultation (Pediatric Neurology/Developmental Behavioral Pediatrics)

□ Psychological evaluation

□ Diagnostic re-evaluation or second opinion

□ Medication management

□ Educational assessment of school consultation

□ Other: __________________________________________________________________

**Please provide the following by Fax: 949-221-0004**

**□ This completed form**

**□ Authorization or if not applicable, a copy of the insurance card**

***To proceed with the intake process, the patient or patient's caregiver/guardian MUST CALL the intake office at 949-267-0447***

Primary Pediatrician Name: ____________________________ Phone: ________________ Fax: ____________

Referring Provider Name: ______________________________Phone: ________________ Fax: ____________

Provider Signature: _____________________________________ Date: ________/________/________________