UCI Health
CENTER FOR AUTISM
& NEURODEVELOPMENTAL DISORDERS

19200 Jamboree Road, Suite 1100 Irvine, CA 92612
t: 657.579.4100 f: 800.316.9711
www.thecenter4autism.org

Referral Request Form

Intake Coordinator Phone: 657-579-4156 **Intake Fax: 800-316-9711**

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: 800-316-9711

□ **This completed form**

□ **Authorization for the following CPT codes: Z7500 x 1, 99205 x 1, 96110 x 1, 99417 x 6, 96127 x 1**
NPI: 1235187311
Tax ID Number: 330706882

□ **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 657-579-4156

Primary Pediatrician Name: _____ Phone: _____ Fax: _____

Referring Provider Name: _____ Phone: _____ Fax: _____

Provider Signature: _____ Date: _____/_____/_____