UNIFI AUTISM CARE

Service Referral Form

CHILD INFORMATION

Child Name: _____

Date of Birth: _____/_____/_____ Child Age (Year/Month): _____ Gender: M ☐ F ☐

Home Address:_____

City: _____ State:_____ Zip: _____

Parent/Guardian: _____ Relationship to Child: _____

Phone: _____/_____-_____ Email:_____ Primary Language: _____

REASON FOR REFERRAL (PICK ONE)

☐ **NO CONFIRMED DIAGNOSIS:**

REFERRAL FOR DIAGNOSTIC TESTING

Has the child been screened with the M-CHAT, STAT or another tool?

☐ YES ☐ NO

If yes, what was the risk level

☐ LOW ☐ MODERATE ☐ HIGH

☐ **CONFIRMED DIAGNOSIS:**

REFERRAL FOR DIAGNOSTIC TESTING

Does the child have a diagnostic report completed by a qualified healthcare professional that clearly states the diagnosis and the evidence used to make the diagnosis?

☐ YES ☐ NO

If yes, who completed?

☐ Self (information below) ☐ Other (please provide)

Name: _____

Email: _____

Phone: _____/_____ -_____

Address: _____

BEHAVIORS OF CONCERN: PLEASE CHECK ALL THAT APPLY

☐ Communication/language concerns
☐ Social interaction concerns
☐ Object play concerns
☐ Joint attention concerns
☐ Cognitive development concerns
☐ Emotional development concerns
☐ Developmental delay
☐ Atypical or inappropriate behavior

Optional: Please add any additional details you would like us to know.

Is the parent or caregiver aware of the referral to UNIFI? ☐ YES ☐ NO

UPON RECEIPT OF THIS REFERRAL, UNIFI WILL

- Assign a Care Navigator to reach out and engage the family to begin the intake process.
- Forward to your office a signed consent for release of medical information and request for a summary of the child's medical record; please inform your front office.
- Provide you with a) the opportunity to contribute to the child's treatment plan b) summaries of the approved plan and c) regular progress reports.

REFERRAL SOURCE

Person Making Referral: _____ Title: _____

Affiliation/Practice Name: _____ Address: _____

City: _____ State: _____ Zip:_____ Office Phone: _____/_____-_____

Email: _____ Signature: _____