Washington University Physicians®
Washington University School of Medicine in St. Louis

Washington University Autism Center Referral Form

The goal of our clinic is to provide 1-4 visits and return the patient to your care.

Clinicians: Please complete this form and fax along with your last office visit note to 314- 396-8266.

Patient Name: _____

Date of Birth: _____

Referring Provider Information

Name: _____

Phone number: _____ Fax number: _____

Are you primary care provider/ specialist / other? (Please circle answer)

Please define your role with the patient if listed specialist/other: _____

1. Autism-related concerns regarding this patient:
   _____
   _____
   _____
2. Screenings/testing performed by your office (i.e., MCHAT, CARS or does the child have an educational classification of autism?)
   _____
3. Past medical history: _____
   _____
4. Other mental health professionals patient has been treated by:
   _____
5. If any interventions have been established (i.e., OT, PT, ABA, Speech), please list here:
   (Don't hesitate to get these started for your patient while this referral is being processed.)
   _____
6. Is the patient on any medications?
   _____
   _____
7. a. Has the patient been evaluated by another autism center? YES or NO (please circle answer)
   b. Is the patient on another autism center wait list? YES or NO (please circle answer)
   c. Is this referral a second opinion? YES or NO (please circle answer)