Washington University Child Psychiatry Referral Form

Autism Clinical Center (ACC)

We are a consultative clinic to provide 1-4 visits with the goal of returning the patient to your care.

Clinicians: Please complete this form and fax, along with patient demographics/insurance coverage and your last office visit notes, 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. Please describe your Autism related concerns regarding this patient.
   _____
   _____
2. Have you performed any screenings/testing within your office (i.e. MCHAT, etc. or does the child have an educational classification of Autism?)
   _____
3. Past Medical History: _____
   _____
4. Please provide name of any other mental health professionals that patient has seen.
   _____
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 current 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 waitlist? YES or NO (please circle answer)
   c. Is this referral a second opinion? YES or NO (please circle answer)