Referral Form
Autism Spectrum Disorder Clinic

Referral type: ☐ Full (needs evaluation of ASD)
☐ Secondary (previous evaluation at other clinic)
☐ Follow-up (previous evaluation at ACN/VOH)
☐ Other _____

Current Diagnosis: _____

Primary Concern for this patient: _____

_____

Please fax this referral to (210) 200-6056

Autism Community Network

Referral Date: _____

Completed by: _____

REFERRAL SOURCE

☐ Physician ☐ School ☐ ECI ☐ Self ☐ Other			Phone:
Name:			Fax:
Address	City/State		Zip code:
Primary Care Physician (if different than referring physician):		Physician Signature:	
TPI #: NPI #:		Phone:	Fax:
Address	City/State		Zip

PATIENT INFORMATION

Patients Name:	DOB	Pt SS#
Mother's Name:	Father's Name:	
Home Address	City/State	Zip
Home Phone:	Alternate contact number:	
Primary language spoken by Parent: ☐ English ☐ Spanish ☐ Other: _____		
Primary language spoken by Child: ☐ English ☐ Spanish ☐ Other: _____		

INSURANCE INFORMATION

Insurance Carrier:		Insurance ID #
Phone #		Group #
Subscriber name:	Subscriber SS#	Subscriber DOB:
Medicaid: ☐ Yes ☐ No	If Yes, Medicaid #:	
Authorization #: (Please attach)		# of visit(s):

CURRENT SERVICES

Please check all that apply:			
☐ Occupational Therapy	☐ Speech Therapy	☐ Behavior Therapy	☐ other
Frequency:			
Agency:	Address:		Phone:
☐ ECI		Agency:	
☐ School Name:		District:	