**View Point Health  
Autism Services Referral**





### Date of Referral:

### Individual’s Name:       DOB:       Age:     SSN:

Is individual currently receiving care from VPH? Y  N  (If Y, please include CID#     )

Individual’s Home Address:       City:       County:       Zip:

Main Phone #:       Email (if applicable)       Is Individual currently homeless? Y  N

Does Individual have a legal guardian? Y  N  (If Y, please include legal guardianship information with referral)

Primary Language:       Emergency Contact Name       Emergency Contact Phone #

Name of Person Referring:       Email:       Phone #:

**Insurance Pre-Visit Checklist:** *Please complete to the best of your ability.*

|  |  |
| --- | --- |
| Insurance Name: | Benefits Number: |
| Member ID: | Group Number: |
| Name/DOB/SSN of Policy Holder: | |
| Do you have secondary or supplemental insurance/payer source? Y  N  (If Y, please include name and policy info#      ) | |

**Does the individual have a *documented* autism diagnosis?** Y  N  **Any other mental health diagnosis?**

|  |  |  |  |
| --- | --- | --- | --- |
| Mood Disorder  ADHD  Down Syndrome | Depression  Anxiety  Bipolar | Phobia  Schizophrenia  IDD | Other:  When was the most recent diagnosis? |

**What location and/or setting is the individual currently living? Please select all that apply**

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| --- | --- |
| Home with family/caregiver (City:       )  Group Home  Own home (Semi/independent living) | CSU  PRTF (Name:      ) |

**What’s the individual’s level of communication?**

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| --- | --- |
| Nonverbal, no functional speech, and doesn’t have a mode of communication they use to get their needs met  Doesn’t engage in any vocal language or words, communicates through pictures, electronic devices, or sign language | Communicates vocally using 1-2 word phrases  Communicates vocally using 3-5 word phrases  Fully verbal, communicates wants and needs in full sentences with full functionality |

**What are the individual’s toilet training needs?**

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| --- | --- |
| Currently wearing diapers, not toilet trained.  Will successfully void in the toilet if verbally reminded on an interval that is less frequent than 1 hour. If not reminded and taken to the restroom they will have accidents.  Will successfully void in the toilet if verbally reminded on an interval that is between 1 - 3 hours. If not reminded and taken to the restroom they will have accidents. | Can independently complete all tasks surrounding independence in voiding in the toilet, but lacks the skill to vocalize their need to use the restroom or request to use the restroom.  Is independently toilet trained, can identify when they need to “go”, will notify an adult/caregiver of this and will use the toilet independently with no assistance. |

**Please identify any current or past Medical/Physical Challenges or Diagnoses and medications: (if applicable)**

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|  |

**Please select any of the following services the individual has received in the past:**

|  |  |
| --- | --- |
| Outpatient mental health services?  If yes where  IDD services? If yes where | Psychiatric Hospital? If yes how many  Homelessness? If yes # of episodes       Jail? If yes # of incarcerations |

**Why are you making the referral? What are the challenging behaviors?**

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| --- |
| *Please list the challenging/problem behaviors that are a reported concern (if any), and what these behaviors look like when they occur. The more information provided in this section, the better.* |

**Supporting Documents?**

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| *In order to expedite the processing of your referral, please include the following supporting documents*  Psychological Evaluation  Diagnostic Evaluation (Must reflect an Autism Diagnosis)  Letter of Medical Necessity (From a Licensed Medical Professional)  IEP documentation (if applicable)  *\*\*\*Please note-Enrollment in the ABA process is contingent upon receiving the above documents. Any delay in obtaining the supporting documents will delay enrollment and the start of treatment.\*\*\** |

**FINAL STEP - Please email referral form and all supporting documents to autism@vphealth.org**

Thank you for the referral. If you do not hear from us within 48 hours, please contact Julie Solinski at (julie.solinski@vphealth.org)

GNETS-Please indicate if this is a GNETS referral