**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**

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

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

|  |  |
| --- | --- |
| [ ]  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?**

|  |  |
| --- | --- |
| [ ]  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