



**Autism Diagnostic Center**

029 O'Donnell Hall  
1220 Stewart St.  
Las Cruces, NM 88001  
Phone: (575) 646-3177  
Fax: (575) 800-0406  
adc@nmsu.edu

**PROVIDER REFERRAL FORM**

*The NMSU Autism Diagnostic Center requires a licensed healthcare provider referral for all clients. This form is to be completed by the licensed healthcare provider that is familiar with the care of the client. Please make sure to complete all required fields and fax to (575) 800-0406. We are not able to process incomplete referrals.*

*\* required*

Today's Date:*	
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**CLIENT INFORMATION**

Child's First Name:*	
Child's Last Name:*	
Gender:*	
Date of Birth:*	

**PARENT/CAREGIVER INFORMATION:**

Parent/Caregiver Name:*	
Address:*	
Telephone:*	
Email Address:*	

**REFERRAL INFORMATION:**

Please complete and attach one of the following screeners for Autism Spectrum Disorder.* <i>Check all that apply*</i> <input type="checkbox"/> Modified Checklist for Autism in Toddlers Revised with Follow-Up (M-CHAT-R/F) <input type="checkbox"/> Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP) <input type="checkbox"/> Social Communication Questionnaire (SCQ) <input type="checkbox"/> Social Responsiveness Scale-2 <sup>nd</sup> ed. (SRS-2) <input type="checkbox"/> Other screener <input type="checkbox"/> Did not complete a screener
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Date screener was completed.*	
What were the results of the screener?*	
Please describe developmental delay(s) and/or differences including manifestation of ASD characteristics (i.e., impairment in social communication, presence of restricted, repetitive, stereotyped patterns of behavior) that your client is exhibiting.*	

**REFERRING PROVIDER INFORMATION:**

Licensed Healthcare Provider Name:*	
Provider Type:*	<input type="checkbox"/> Pediatrician <input type="checkbox"/> PCP <input type="checkbox"/> CNP <input type="checkbox"/> Psychologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Mental Health Counselor <input type="checkbox"/> Speech-Language Pathologist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Early Intervention/FIT Provider <input type="checkbox"/> School-based Health or Educational Professional <input type="checkbox"/> Other
Practice Name:*	
Provider Phone Number:*	
Provider Email:*	

*I certify that I am the child's licensed healthcare provider or office representative of the healthcare provider completing this form.*

\_\_\_\_\_  
 Print Name:

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date