 **College of Health, Education and Social Transformation**

NMSU Autism Diagnostic Center

029 O’Donnell Hall

1220 Stewart St.

Las Cruces, NM 88001

Phone: (575) 646-3177

Fax: (575) 800-0406

**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.

|  |  |
| --- | --- |
| Date: |  |

**CLIENT INFORMATION**

|  |  |
| --- | --- |
| Child’s First Name: |  |
| Date of Birth: |  |
| Gender: |  |
| Child’s Last Name: |  |
| Age: |  |
| Languages Spoken: |  |

**PARENT/CAREGIVER INFORMATION:**

|  |  |
| --- | --- |
| Parent/Caregiver Name: |  |
| Relationship to Child: |  |
| Address: |  |
| Telephone: |  |
| Email Address: |  |

**REQUIRED SCREENER INFORMATION:**

|  |
| --- |
| Please complete and attach one of the required screeners related to Autism Spectrum Disorder.  \_\_\_\_\_ Modified Checklist for Autism in Toddlers Revised with Follow-up (M-CHAT-R/F)  \_\_\_\_\_ Social Communication Questionnaire (SCQ)  \_\_\_\_\_ Social Responsiveness Scale-2nd ed (SRS-2)  \_\_\_\_\_ Survey of Wellbeing of Young Children (SWYC)  \_\_\_\_\_ Other screener: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| 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. | |

**RE-EVALUATION, Specific For Those with Previous ASD Diagnosis Requiring Re-evaluation**

Date Evaluation was completed:

Diagnosing Provider Name/ Agency/ State:

**REFERRING PROVIDER INFORMATION:**

|  |  |
| --- | --- |
| Licensed Healthcare Provider Name: |  |
| Provider Type:  **Pediatrician PCP CNP**  **Psychologist Social Worker Mental Health Counselor Speech-Language Pathologist Occupational Therapist**  **Early Intervention/FIT Provider School-based Health or Educational Professional**  **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