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:		Child's Last Name:	
Date of Birth:		Age:	
Gender:		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.	

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