Children's Clinics
Comprehensive Care for Kids & Teens

Patient Label

Referral Form
ASD Multi-Disciplinary Center of Excellence

Services Requested: Enroll child in ASD Multi-Disciplinary Center of Excellence

Enrolled in Preschool/School: Yes ☐ ☐

Name of School/Preschool: _____

Name of Parent or Guardian(s):_____

Address: _____

Email address: _____

Phone Number: _____ Mobile ☐ Home ☐

Referral Source:

- ☐ Primary Care
- ☐ Insurance Plan _____
- ☐ Developmental Pediatrician
- ☐ Psychiatrist
- ☐ Neurologist
- ☐ Other: _____

Criteria for Referral (check all that apply):

- ☐ Under the age of 10
- ☐ Recently diagnosed with ASD (in the last 12months)
  - Psychiatry, Neurology or Developmental Pediatrician diagnosis note required
- ☐ ADOS or DSM 5 of at least a 2 or a 3
- ☐ Complex medical condition in addition to ASD
  - Documentation of complex medical condition by a Specialist required

Reason for referral/concerns:

_____
_____
_____
_____
_____

Submit referral to:
colleen.hara@childrensclinics.org or fax to 520-324-3457 Attention Colleen Hara

Children's Clinics Staff only:
Date Referral Received: _____
Meets all enrollment criteria: Yes _____ No _____
Appointment Scheduled: Date _____ Time _____
RN Signature: _____