UNIVERSITY *of* MISSOURI

THOMPSON CENTER FOR AUTISM & NEURODEVELOPMENTAL DISORDERS

Referral Form

Patient Information *(All fields must be completed)*:

Patient Name: _____ Date of Birth: _____ Age: _____ Gender_____

Parent/Guardian:_____ Relationship:_____

Address:_____ City:_____ State: ____ Zip:_____

Home Phone:_____ Cell Phone:_____ Other: _____

Email: _____

Referral Information (*Must be a health professional, school professional, or community agency)*

Date:_____ Agency: _____

Referred By (Name & Title): _____

Phone Number: _____ Fax Number: _____

INSTRUCTIONS:

Autism Related Referrals (Section 1)

- There is a concern patient may have an Autism Spectrum Disorder diagnosis:
  - Complete Section 1A (Autism Referral: New Diagnosis)
- Patient already has an autism spectrum disorder diagnosis by MD, DO, or PhD:
  - Complete Section 1B (Autism Referral: Previous Diagnosis).

All Other Referrals (Section 2)

- Patients needing diagnostic assessments, treatment planning, medical supports, or intervention services:
  - Complete Section 2 (Non-Autism Referral).

Once the referral form is completed, please fax or email along with any patient records to the Thompson Center Referral Team, **Fax #: 573-884-8529, Email: ThompsonCenterReferralTeam@missouri.edu** Referring agency will not be responsible for payment unless otherwise noted. Any questions regarding referrals, please call **573-884-8335**.

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SECTION 1: AUTISM REFERRALS

Does the patient have a previous diagnosis of an Autism Spectrum Disorder?

☐ NO (Complete section A)

☐ YES (Complete section B)

Section A: New Diagnosis

Has this patient been evaluated for an ASD in the past, but was found to not have an ASD diagnosis?

☐ YES ☐ NO

Service Requested

☐ **Autism Diagnostic Services** (Provides comprehensive medical and behavioral diagnostic evaluation for individuals who may have an autism spectrum disorder)

Please provide a description of symptoms/concerns you have identified: _____

_____

_____

Section B: Previous Diagnosis

Provide the following information regarding patient's **current** diagnosis of Autism Spectrum Disorder:

Diagnosis given by: _____Type of Provider (e.g., MD, DO, PhD):_____

Facility where autism diagnosis was made: _____

Please provide a description of symptoms/concerns you have identified:_____

_____

Service Requested

Medical Services

☐ **Autism Medical Clinic** (Provides medical treatment and long-term management for individuals who have an autism spectrum disorder)

Applied Behavior Intervention Services Division (Select from the following services)

☐ **Toilet Training**

☐ **Social Skills**

☐ **Applied Behavior Analysis (ABA)**

Psychological Testing Provides diagnostic, cognitive and behavioral assessment and consultation for children and adults with Autism Spectrum Disorder (Select from the following reasons)

☐ **Question accuracy of ASD diagnosis**

☐ **Transition Planning**

☐ **Re-evaluation to check progress (Cognitive functioning, learning, etc)**

☐ **New concerns (Behavioral, Social, Emotional)**

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SECTION 2: NON-AUTISM REFERRALS

Please list any current diagnosis:_____

Please provide a description of the three primary concerns/symptoms you have identified:

_____

_____

_____

Psychological Testing Provides diagnostic, cognitive and behavioral assessment and treatment recommendations for children and adults with neurodevelopmental or developmental concerns (Select ***one*** from the following services)
** Please note age ranges.

- ☐ **ADHD Testing** (This clinic does not include medication management) **Ages 5 and up**
- ☐ **Learning and Intelligence Concerns** (Learning and intellectual disabilities, conservatorship) **Ages 6 and up**
- ☐ **Neuropsychological Testing** (cognitive concerns related to ***neurological/medical conditions***) **Ages 0 - 20**

Medical Clinics (Select from the following services) **Ages birth to 13 years**

- ☐ **Developmental Behavioral Clinics** (Medical assessment & treatment (including medication management) services for children previously diagnosed with developmental delays, ADHD, anxiety, and behavior concerns)

- ☐ **Special Needs Clinic** (Coordination of medical care for children with more complex special health care needs. This includes assessing patient for nutritional issues and various therapy service needs, including speech therapy, occupational therapy, and physical therapy. Evaluations may be performed depending on availability of therapist. Otherwise, appropriate referrals will be made.)

PLEASE NOTE: To qualify for services listed below, the patient must have a neurodevelopmental diagnosis (e.g., Fragile X, Developmental Delays, Down Syndrome, Cerebral Palsy) to qualify for services.

Applied Behavior Intervention Services Division (Select from the following services)

- ☐ **Toilet Training**
- ☐ **Social Skills**
- ☐ **Applied Behavior Analysis (ABA)**