Referral Form

Adult Autism Center
of Lifetime Learning
A SERVICE OF PINGREE

Date of Referral: _____

Parent/Guardian Information

Your Name: _____

Email Address: _____

Phone Contact: _____

Home Address: _____

_____

Information about the adult referred to the Adult Autism Center

Full Name: _____

Address (if different from Parent/Guardian address above):

_____

_____

Date of Birth: _____ Age: _____ Gender: _____

Diagnoses: _____

Medical Conditions and/or Allergies: _____

_____

Medications: _____

Medicaid (yes or no): _____ DSPD (yes or no): _____ SSI (yes or no): _____

Private Insurance (name of plan): _____

Any other funding: _____

Please complete this referral form and send to AdultAutism@CarmenBPingree.com

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Description of the adult with autism (approximate level of functioning in terms of cognitive, language, and self-help skills development- previous and current treatments or interventions being provided, anything else you wish to share about your child):

Describe strengths:

Describe areas of need that you would like to be goals of treatment:

Describe any behaviors (i.e. aggression, noncompliance, self-injurious, tantrums):