easterseals Central Illinois

Referral Form

Client Name: _____ DOB: _____ ☐ Male ☐ Female

Referral Source: _____ Phone : _____

Services(s) Requested:	☐ Applied Behavior Analysis (ABA)	☐ Feeding Therapy	☐ Social Skills Group (Autism)
	☐ Assistive Technology	☐ Occupational Therapy	☐ Speech Therapy
	☐ Augmentative & Alternative Comm. (AAC)	☐ Orthotics	☐ Splints
	☐ Counseling	☐ Physical Therapy	

Autism Diagnostic Service Requested:	ASD Evaluation	M-CHAT Scores (if age 3 years or younger)
	☐ ADOS 2 (Only)	Total Number Failed: _____
	☐ Specialized Team (Multi-Disciplinary)	Critical Items Failed: _____

Reason for Referral: Symptom(s)/Condition(s)	

Current Diagnosis:	

Primary Care Physician:	Name:
	Phone:

Parent/Legal Guardian:	Name:	
	Address:	
	Home Phone:	Cell Phone:

Insurance Carrier:	Name:

Please Fax or Mail:
1.Referral Form
2.Signed Rx

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