Referral Form

Client Name: _____ DOB: _____ ☐ Male ☐ Female

Services(s) Requested:	☐ Applied Behavior Analysis (ABA) ☐ Feeding Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy	☐ Assistive Technology Clinic ☐ Orthotics Clinic

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

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

Current Diagnosis:	

Referring Provider:	Name:
	Phone:

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

Insurance Carrier:	Name:

Please Fax:
1. **Referral Form**
2. **Signed Rx**

Easterseals Central Illinois
Peoria/Bloomington Service Centers
Fax: (309)686-7722

For Questions: Intake Specialist (309)686-1177 ext. 2203