



Referral Form

Client Name: _____ DOB: _____ Male Female

Services(s) Requested:	<input type="checkbox"/> Applied Behavior Analysis (ABA)	<input type="checkbox"/> Assistive Technology Clinic
	<input type="checkbox"/> Feeding Therapy	<input type="checkbox"/> Orthotics Clinic
	<input type="checkbox"/> Occupational Therapy	
	<input type="checkbox"/> Physical Therapy	
	<input type="checkbox"/> Speech Therapy	

Autism Diagnostic Service Requested:	<u>ASD Clinic:</u>	<u>M-CHAT Scores (if age 3 years or younger)</u>
	<input type="checkbox"/> ADOS-2/CARS-2 (Evaluation Only)	Total Number Failed: _____
	<input type="checkbox"/> Multi-Disciplinary Team Evaluation	Critical Items Failed: _____

Reason for Referral: Symptom(s)/Condition(s)	
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Current Diagnosis:	
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Referring Provider:	Name:
	Phone:

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

Insurance Carrier:	Name:
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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