Autism DELAWARE

REFERRAL for Services

Autism Delaware's Referral Services support the needs of youth up to age 18, with ASD (diagnosed) and their families to connect to services and supports.

Please fill out this form completely and email to referrals@delautism.org or fax (attention Melanie Matusheski):
New Castle County: Phone: 302-224-6020 Fax: 302- 224-6017

Child's Information

Child Name: _____ DOB: _____

Gender: ___ Male ___ Female Resides with: _____

Parent/Legal Guardian Information

Parent Name: _____ Phone: _____

Relationship to Child: _____ Alternate Phone: _____

Address: _____

Insurance Information

Medicaid? ___Yes ___No MCO: _____

Private Insurance: _____

Clinical Information

Reason for Referral: _____

Has this child been diagnosed medically with autism spectrum disorder? ____ Yes ___No
Has this child been educationally classified as a child with autism? ____ Yes ___ No
Has this child had an autism evaluation? ___Yes ___No

Current Diagnoses: _____

Treatment Plan

What is the referral agent treating the client for?

Treatment goals?

REFERRAL for Services, continued

What goals are in the client's treatment plan for peer support? Check all that apply.

- ☐ Outreach and Information
- ☐ Bridging & Coordination of Services
- ☐ Parent/Guardian/Caregiver Psychoeducation
- ☐ Community Connections and Natural Supports

Referral Agent Information – Professional Completing this Referral

Name: _____ Position: _____

Agency: _____ Phone: _____

Email: _____

If outpatient mental health therapist is not referral agent, please provide information for client's mental health provider:

Therapist Name: _____ Phone: _____

Agency: _____ Email: _____

Parent Consent

I understand that I have certain rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including right to privacy regarding my protected health information, including information shared in this referral. I agree for the provider listed above as "Referral Agent" to complete this form and share the information included with Autism Delaware for the purposes of referring my child for peer family support services. *I further agree that Autism Delaware Family Peer Support Services staff may contact the provider listed in this referral form in order to coordinate the referral.*

This consent to share information will be effective for 12 months from the date of my signature below, or until _____. I understand that I have the right to revoke this consent at any time and no further information will be shared as of that time.

I understand that, following the initial intake, Autism Delaware will recommend the most appropriate Family Support Program.

_____ _____

Parent/Guardian Signature Date

_____

Printed parent/Guardian Name

_____ _____

Referral Agent Signature Date