Autism DELAWARE

REFERRAL for ACT Services

Autism Delaware's ACT Services support the needs of youth with ASD (diagnosed) and their families through the evaluation and assessment process into connection to services and supports.

**Fees for this service are currently being waived during our pilot program, and may be covered by insurance in the future **

Please fill out this form completely and fax it to Autism Delaware 302- 224-6017 or email to referrals@delautism.org

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 ACT Services, continued

What goals are in the client's treatment plan for peer support?

- ☐ 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/Practice: _____ Phone: _____

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 ACT 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 6 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 Autism Delaware will determine the most appropriate service for my family following my initial intake appointment with them.

_____ _____
Parent/Guardian Signature Date

_____
Printed parent/Guardian Name

_____ _____
Referral Agent Signature Date