Center for Autism and Developmental Disabilities
Appointment Request

University of Texas Southwestern Medical Center at Dallas • Children's Medical Center of Dallas

Office: 214.648.0102 Fax: 214.867.5389

❶ What is the primary diagnosis?

- ☐ Autism Spectrum Disorder
  - ○ Suspicion of ASD Diagnosis
  - ○ Behavioral Problems
- ☐ Fragile X
- ☐ ECMO
- ☐ TBI with Cognitive Problems
- ☐ Intellectual Disability
- ☐ Global Developmental Delay
- ☐ Developmental Regression
- ☐ Chromosomal/Genetic Abnormality
- ☐ Microcephaly
- ☐ Other: ____

❷ Indicate the reason for the appointment request:

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What concerns do you have about the patient that prompted a referral here?

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❸ Records Needed:

Patients Ages 0-3

- Medical records including all MRIs, EEGs, and blood work
- Any prior evaluations, if available (e.g., ECI, therapies, ASQ-3)
- For Autism Spectrum Disorders: ASD screeners (Failed MCHAT for toddlers <u>OR</u> pediatrician's statement of suspicion of autism)

Patients Ages 3 and up

- School records (FIE [evaluation] and ARD records)
- Medical records including all MRIs, EEGs, and blood work
- Any prior evaluations, if available

❹ **IMPORTANT NOTICE**

*Some insurance plans do not cover all services offered. If we are unable to obtain an authorization, the patient may be referred to a provider recommended by the insurance plan or back to the PCP for management.

*Please fax completed forms with copies of all records indicated in Box 3 to (214) 867-5389

* Patient's turning 18 within six months will need to be referred to an adult specialist.

*<u>**All records are needed before the referral can be reviewed and thus scheduled. We will contact the family to schedule the appt once all information is received and reviewed.**</u>

Provide patient information:

Child's Name: Last ____________ First ____________ Middle ____________ DOB:__________ AGE: ______ SEX: ___

Referring MD: __________________________ MD Phone: ________________________ MD Fax: __________________________

Family Contact #s: Home: _______________________ Work: _______________________ Other: __________________________

Parent Name(s)_____________________________________ Parent Address ____

Insurance:_________________________Subscriber ID:_______________________________Group:#________________________

Current Medications: ____

Other medical problems/diagnosis: ____

Other Specialist who has seen this child (name and specialty): ____