

**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**

**1** 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: \_\_\_\_\_

**2** Indicate the reason for the appointment request:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3** 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 or evidence of possible 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

**4 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.

**\*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.**

Provide patient information:

Child's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

Referring MD: \_\_\_\_\_ MD Phone: \_\_\_\_\_ MD Fax: \_\_\_\_\_

Family Contact #: 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): \_\_\_\_\_