Evaluation Referral Form
Adult Autism or ADHD

Please use this form to provide the information about the reason for referral, goals for the evaluation, and to elaborate on potential factors that could influence the validity of the evaluation. Please contact Dr. Christie Seiler at 518-538-1000 if you are uncertain if an evaluation is appropriate for a patient. We will only follow up on referrals that are appropriate and meet the conditions noted at the beginning of this form.

Note: We require that all individuals undergoing an evaluation have a clean drug screen within 30 days before proceeding with the evaluation. The individual will be scheduled for an in-person intake evaluation and be expected to bring the copy of the drug screen results (i.e., for all potential substances) ordered by their doctor or other medical provider.

Note: We will not complete an ADHD or ASD evaluation if there is an active substance abuse issue or any psychosocial issue leading to acute instability (i.e., SI, DV, etc.) that could impact the validity of the evaluation. Please only refer individuals who are stable medically and psychiatrically, not abusing substances, and not involved in ongoing domestic violence, as these could interfere with the validity of the assessment. Instead, you can refer them for treatment and, when they are stable enough and if an evaluation still seems medically necessary, we can proceed with the evaluation.

Note: We are only doing evaluations for Autism if the individual needs documentation for SPOA, OPWDD, AccessVR, college/school, or another agency. We are unable to do an Autism evaluation if the sole purpose is to provide documentation for the courts. Please do not refer an individual for an Autism evaluation if they are functioning well but only expressing curiosity about whether they have the diagnosis. If the request for an evaluation is only for curiosity, we recommend that they pursue outpatient mental health treatment as a potential other avenue to clarify their concerns.

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Adult Autism or ADHD

Date:_____

Name of Referring Professional: _____

Referring Agency:_____ **Phone #:**_____

Client Name:_____

Gender Assigned at Birth:_____

Gender:_____ **Pronoun Preference:** _____

Client Contact Phone: _____

1) Is this a referral for:

ADHD

ASD

2). Do you have concerns about factors that could influence the evaluation?

General cognitive/intellectual function

General psychological function

Personality disorder

Other condition: _____

3). Is this evaluation due to a referral for one of the following agencies:

SPOA

OPWDD

College or other school

Court

CPS

Other: _____

3) What are the symptoms that they have noticed that are prompting the referral for an evaluation:

Inattention/Distractibility

Forgetfulness

Poor Time Management

Procrastination of non-preferred activities

Hyper-focus on preferred activities

Disorganization/Messiness

Hyperactivity/Impulsivity

Troubles making or keeping friends

Difficulty developing or maintaining relationships

Deficits in non-verbal communication

Deficits in social-emotional reciprocity

Repetitive or stereotyped motor movements

Obsessive with routine or sameness

Highly restricted or fixated interests

Hyper- or hypo-reactivity to sensory stimulation

4). Do you believe the evaluation is medically necessary (i.e., will result in clinically significant changes to the patient's treatment plan and/or overall functioning? Yes No

5). Do they have any of the following:

Legal or court issues (past or pending), including Protection orders: Yes No
Explain:

Domestic Violence concerns: Yes No
Explain:

Alcohol or Substance use or abuse concerns: Yes No
Explain:

Self-harm thoughts/ideation or gestures: Yes No
Explain:

Suicidal thoughts/ideation, gestures, or attempts: Yes No
Explain:

Homicidal/Violent thoughts/ideation, gestures, or attempts: Yes No
Explain:

By signing below, I indicate that I have read and understand this form.

_____	_____	_____
Signature of Referring Provider	License # of Referring Provider	Date