Note: We require that this entire form be completed in its entirety **by the referring provider** before scheduling. If we verify that this form was completed by the patient, or a patient representative, instead of the referring provider indicated on the form, **we will not schedule, and we will cancel all scheduled services**.

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 a copy of the drug screen results.

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.

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Evaluation Referral Form
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