Therapeutic Early Autism Program of WBH/UPMC
REFERRAL FORM
2400 East Carson Street Pittsburgh, PA 15203
Phone: 412.310.9478 Fax: 412.431.5739
Questions? Call Carine VanBuren 412.713.0855

Please fill out form entirely.
*** Providing specific details about your child is extremely helpful!***

Demographic Information

Child's Name:	**Gender** _____
Child's Birth date: _____ **Age:**_____	**Medical Assistance Number:** _____ ☐ **Application submitted, number pending**
Residence (Parents, Grandparents, Foster Home, other living arrangement) _____	
Parent(s)/Guardian Name:	
Address:	**Phone:** **(Home)**_____ **(Cell)** _____ **(Work)**_____ **Email:**_____
Preferred Language for Parent:_____	**Child:** _____
Are there any cultural, language, or religious considerations you would like us to know to aid/improve treatment for your child and family?	
When calling, may we leave a message at the above number(s) identifying our program? ☐ **Yes** ☐**No** **Comments:**	

Family Information

Household Members (Name/Relation to child/Age):
Others Involved in Direct Care of Child (Name/Relation to child/Age)

Health Information

Is your child taking any medications? ☐ Yes ☐ No

Medication **Dosage** **Prescribing Doctor**

_____

Significant Medical Conditions and/or Allergies: ☐Yes ☐No Describe:

_____

Primary Care Physician/Pediatrician (Doctor/Practice) _____

_____

Address:_____

Phone:_____

Diagnostic Information

Please provide your child's current diagnoses:

Behavioral Health Diagnosis: _____

Behavioral Health Diagnosis: _____

Behavioral Health Diagnosis: _____

Medical Conditions/Physical Health Issues (if applicable): _____

Date of most recent psychological evaluation: _____

****If you have a copy of a psychological evaluation, please feel free to include***

Insurance Information

Act 62

Act 62 requires private health insurance companies to begin covering the costs of diagnostic assessments for autism and services for individuals with autism who are under the age of 21. It requires the PA Dept. of Public Welfare to cover the costs for individuals who have no insurance coverage or for individuals whose costs exceed $36,000 annually.

We will assist you in determining whether Act 62 applies to your child's insurance if you are not sure.

Does Act 62 apply to your child's insurance? ☐ Yes ☐ No ☐ Not Sure

Primary (Commercial) Insurance Information: Provide information below or ☐ N/A

Insurance Company Name:

ID Number:

Insurance Phone Number:

Insurance Holder (subscriber) Name:

Subscriber's DOB:

Relationship to child:

Group Number:

Renewal Date:

Clinical and Behavioral Information

Communication Skills (Describe how your child typically communicates their wants and needs):

Does your child use any non-vocal methods of communication? (PECS, sign language, pulling adult to item, pointing, etc.) Describe:

Please share information on the following behaviors/situations and describe as best you can

Aggression (hitting, kicking, biting, hair pulling, etc. to self and/or others) ☐ Yes ☐ No Describe:

Tantrums (intense crying/screaming, body flopping, etc.) ☐ Yes ☐ No Describe:

Safety Concerns (elopement/running away; difficulty riding in car; lacking appropriate fear response of water, strangers, heights, etc.) ☐ Yes ☐ No Describe:

Fears/Anxiety ☐ Yes ☐ No Describe:

Oppositional (refusal to follow instructions, argumentative) ☐ Yes ☐ No Describe:

Mood Related Issues (tearfulness, irritability, mood swings, etc.) ☐ Yes ☐ No Describe:

Intense/Unusual Interests (focus on specific topics or objects, repeating lines from videos/TV shows, play with only certain types of toys) ☐ Yes ☐ No Describe:

Stereotypical Behaviors (hand flapping, rocking, looking at items from different angles, lining things up, spinning objects etc.) ☐ Yes ☐ No Describe:

Property Destruction (breaking toys, tearing books, etc.) ☐ Yes ☐ No Describe:

Social Skills Deficits/Difficulties interacting with peers (refusal to share toys, avoidance of peers, limited eye contact, lack of joint attention) ☐ Yes ☐ No Describe (please describe positive social skills as well):

Educational Issues (difficulty paying attention to adults, staying in seat/area, responding to adult directives) ☐ Yes ☐ No Describe:

Does your child have difficulty separating from anyone in the family and/or does anyone in family have difficulty separating from child? ☐ Yes ☐ No Describe:

Other Behavioral Concerns/Issues not noted above Describe:

Overall Health and Self-Care

Feeding/Eating Issues (limited diet, GFCF, food tolerance, does child feed self? etc.) ☐ Yes ☐ No Describe:

Food allergies ☐ Yes ☐ No Describe:

Sleep Issues/Concerns (does your child nap?) ☐ Yes ☐ No (Describe sleep pattern):

Toileting/Potty Training (use of pull ups/diapers, constipation/diarrhea issues, any potty training attempts) Describe:

Any concerns or strengths regarding siblings? ☐ N/A ☐ Yes ☐ No Describe:

CYF (Children/Youth & Families)/Child Protective Services Involvement ☐ Yes ☐ No Describe:

History of Abuse ☐ No ☐ Verbal ☐ Physical ☐ Sexual

Child and Family Strengths

Child:

Family:

Family Resources

1) How do you get to store/appointments, etc.?

◯ **Own Car** ◯ **Bus/public transportation** ◯ **Rely on friends/family** ◯ **MATP or similar program**

Comments:

2) If you need someone to watch your child when you need to go somewhere, is that:

◯ **Possible** ◯ **Possible, but challenging** ◯ **Very difficult** ◯ **Not an option**

Comments:

3) Do you, the parent/guardian, have someone to talk to when feeling stressed or need support?

◯ **Yes** ◯ **Not really**

Comments:

4) In relation to your child's autism diagnosis, do you feel supported by family and friends?

◯ **Yes** ◯ **No** **If no, please explain (ex. others don't agree that child has ASD, do not want child around them due to challenging behaviors, etc.):**

5) Is your child available to participate in the TEAP program from 8:30 AM – 2:30 PM Monday-Friday?

6) Are you or another adult able to provide transportation to and from TEAP every day?

CURRENT SERVICES AND SERVICE HISTORY

SERVICES RECEIVED	AGENCY	CONTACT PERSON/ PHONE NUMBER	SERVICE DATES
Service Coordination / Case Management (examples include Alliance for Infants/Toddlers, Family Links, Mercy, Chartiers MH/MR, etc.)			
Crisis Services (ACES, Re:solve)			
CYF/Child Protective Services			
FBMHS (Family Based Mental Health Services)			
Inpatient Hospitalization			
Outpatient Therapy (include outpatient speech, OT, PT)			
School Setting What school district do you live in? Does your child have an IEP (ages 3 and up)?			
Therapeutic Services (DART or Pittsburgh Public) ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech ☐ Itinerant/Developmental			
Wraparound (BHRS/IBHS)			
Other (including childcare)			

Other comments/information not noted above that you would like to share with us:

Thank you for taking the time to completely fill out this information. It is appreciated and helpful in determining what level of service would most benefit your child.