Referral for Diagnostic Evaluation

To: **Autism Discovery Institute** ______ **Phone #:** **(858) 966-7453** ___ **Fax #:** **(858) 966-8011**

From: ______________________________ **Phone #:** _________________ **Fax #:** ______________

Date: _______________________________ **Re:** **Referral for Full Evaluation at Autism Discovery Inst**

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REFERRAL INFORMATION:

Child's Name: ___________________________ **DOB:** _________ **Child's Language:** ______________

Caregiver's Name: _____________________________ **Relationship to Child:** _______________________

Address ____

City ________________ **State** _____ **Zip Code** ________ **Caregiver's Language:**_________________

Home Phone # ________________ **Work Phone #** ________________ **Cell Phone #** _________________

Reason for Referral: ____

FOR PHYSICIAN REFERRALS:

Primary Care Physician: _____________________ **Center:**________________ **Phone #**______________

Carrier:_______________________________________ **Policy #:**____________________________________

Subscriber Name: _____________________________ **Effective Date:** ______________________________

FOR REGIONAL CENTER REFERRALS:

SD Regional Center Case Manager: ________________________ **Phone #:** ________________________

UCI # ______________________________