755 S. Telshor Blvd., Ste. Q102
Las Cruces, NM 88011
Phone: (575) 888-4666
Fax: 1- 888-473-9160
autism@telshorbehavioral.com

REFERRAL FORM

This form should be completed by a licensed healthcare provider currently treating the client.

Today's Date:	

CLIENT INFORMATION

Child's First Name:	
Child's Last Name:	
Gender:	
Date of Birth:	
Primary Insurance:	

PARENT/CAREGIVER INFORMATION:

Parent/Caregiver Name:	
Address:	
Telephone:	
Email Address:	

REFERRING PROVIDER INFORMATION:

Licensed Healthcare Provider Name:	
Provider Type: (e.g., pediatrician, CNP, PCP, early intervention provider, ABA Provider, etc.)	
Practice/Agency Name:	
Provider Phone Number:	
Provider Email:	

REFERRAL INFORMATION:

Was an autism screening (e.g., M-CHAT-R/F, SCQ, SRS-2) completed? ☐ Yes ☐ No	
What were the results of the screening (e.g., Medium Risk, High Risk)?	
Was child previously evaluated and diagnosed with Autism Spectrum Disorder? ☐ Yes ☐ No	
Date screener or previous evaluation was completed.	
Please describe any specific developmental and/or behavioral concerns that suggest need for further evaluation.	

Please fax this form and any additional documents (e.g., Release of Information, CME, IFSP, previous evaluation(s), Current ABA treatment plan) to 1-888-473-9160

I certify that I am the child's licensed healthcare provider or office representative of the healthcare provider completing this form.

_____
Print Name:

_____ _____
Signature Date