Instructions:

Please include the enclosed form when referring an IEHP patient for an Autism Spectrum Disorder or other Neurodevelopmental Disorder comprehensive diagnostic evaluation. IEHP uses the included parameters to determine medical necessity for a comprehensive diagnostic evaluation.

You may also send a copy directly to the Inland Empire Autism Assessment Center of Excellence using the fax number or email button at the end of the document.

IEHP REFERRAL FOR EVALUATION & DIAGNOSIS

ASD and Other Neurodevelopmental Disorders

Date: _____

Name of Patient: _____

Current Caregiver: _____

Relationship of Current Caregiver to Patient (e.g. biological parent, foster parent):

_____

DOB:_____

IEHP ID#: _____

Referring Physician _____

Referring Agency: _____

Agency Phone Number: _____

Age of Child at Time of Referral: _____

Please <u>check all that apply</u> below:

- **Any out of Home Placement (Current OR History)**
  - ☐ Foster
  - ☐ Kinship (grandparent or other family member)
  - ☐ Adoption
  - ☐ Involvement with Child & Family Services

- **Trauma History (Current OR History)**
  - ☐ Physical Abuse
  - ☐ Emotional Abuse
  - ☐ Sexual Abuse
  - ☐ Physical Neglect
  - ☐ Emotional Neglect
  - ☐ Separation from Parent
  - ☐ Household Mental Health Concerns
  - ☐ Household Substance Abuse Concerns
  - ☐ Domestic Violence
  - ☐ Community Violence

☐ Medical Trauma Hx

☐ Other Trauma _____

- **Mental Health Symptoms (of Patient)**

  ☐ Mania

  ☐ Depression

  ☐ Aggression

  ☐ Self-injurious Behavior

  ☐ Suicidal Ideology

  ☐ Anxiety

  ☐ Hyperactivity

  ☐ Conduct Problems/Behavioral Issues & Concern

  ☐ Obsessive or Compulsive Behaviors

  ☐ Animal Harm

  ☐ Destructive Behaviors

  ☐ Elopement/Escape Behavior

  ☐ Frequent Dysregulation

  ☐ Psychosis (e.g. hallucinations, delusions etc.)

- **Chronic Illnesses/Medical Conditions/Genetic**

  ☐ Diabetes

  ☐ Seizures

  ☐ Prematurity

  ☐ Asthma

  ☐ Cerebral Palsy

  ☐ Auto Immune

  ☐ Traumatic Brain Injury

  ☐ Sleep Disorder/Disturbance

  ☐ Failure to Thrive

  ☐ Prenatal Drug Exposure

  ☐ Fetal Alcohol Spectrum Disorder

☐ Hearing/Auditory Problems

☐ Visual Disturbance

☐ Cleft Palate/Craniofacial Deformities

☐ Downs Syndrome

☐ Other Syndrome (suspected or confirmed)

☐ Chromosomal Abnormality (suspected or confirmed)

☐ Maltreatment – Abuse and/or neglect

Please list any other medical, developmental, or behavioral concerns or special considerations for this child (including maternal pregnancy risk factors, delivery complications, NAT, or accidental injuries):

Requested Evaluation(s)

☐ Transdisciplinary Evaluation – Medical/Psychological/OT/Sp/L etc

☐ Neurological important to the evaluation of this child

☐ Psychological important to the evaluation of this child

Requested Agency:
Inland Empire Autism Assessment Center of Excellence

Please email or fax completed forms to:
Email: info@ieaace.com
Fax: (909) 799-5999

San Bernardino Location:
1499 S. Tippecanoe Ave. Bldg. A
San Bernardino, CA 92408

Riverside Location:
19314 Jesse Ln. STE 200
Riverside, CA 92508

Email Form

Print Form