Referral Form

Patient Information *(All fields must be completed)*:

Patient Name: ______________________________________ Date of Birth: ___________ Age: _____ Gender_____

Parent/Guardian:____ Relationship:__________________________

Address:____ City:________________ State: ____ Zip:__________

Home Phone:__________________ Cell Phone:___________________________ Other: ________________________

Email: ____

Referral Information

Date:_________________________ Agency: ____

Referred By (Name & Title): ____

Phone Number: __________________________________ Fax Number: ______________________________________

INSTRUCTIONS:

Autism Related Referrals

- There is a concern the patient may have an Autism Spectrum Disorder diagnosis:
  - Complete Section 1A (Autism Referral: New Diagnosis)
- Patient already has an autism spectrum disorder diagnosis by MD, DO, or PhD:
  - Complete Section 1B (Autism Referral: Previous Diagnosis).

Once the referral form is completed, please fax or email along with any patient records to the Mercy Autism Collaborative, **Fax #: 417-820-6580, EMAIL:**

Referring agency will not be responsible for payment unless otherwise noted. Any questions regarding referrals, please call **417-820-2229**.