Autism Assessment
Referral Form

Select Clinic: ❑Clemmons ❑Greensboro ❑Greenville ❑Wilmington

Date of Referral:	Parents aware of referral (Y/N):
Client Information	
Client Name:	Date of Birth:
Street Address: City: State: Zip:	
Contact Number(s):	Email:
Caregiver/Parent Name(s): _____ Caregiver type: ❑ Biological Parent ❑ Legal Guardian ❑ Foster Parent ❑ Other: _____ Is the child in DSS custody? ❑ Yes ❑ No DSS Caseworker Name: _____ Caseworker Contact#_____	
Insurance Information	
Primary Insurance:	Member ID:
Secondary Insurance:	Member ID:
Referral Information	
Referring Provider:	NPI:
Practice Name:	
Fax Number:	Callback Phone:
Purpose of referral: ☐ Rule out/confirm Autism	
Has the client received autism or other psychological testing within the last 12 months? ❑ Yes ❑ No If Yes, Date:_____ Dx: _____*Note: Insurance coverage may vary if prior testing has been done.*	
Please send the following information with the referral to avoid issues with insurance preauthorization: ❑ Encounter Summary/Clinical Notes– detailing presenting symptoms warranting testing ❑ Copy of previous testing assessment/reports (documentation of diagnosis/date received)	
RETURN VIA FAX: 252-565-4505 or **EMAIL**: TESTINGINTAKE@BCPS-AUTISM.COM	