UNIVERSITY OF SOUTH DAKOTA
SANFORD SCHOOL OF MEDICINE

Center for Disabilities
Dedicated to Life Without Limits

1400 West 22nd Street • Sioux Falls, SD 57105-1570 • 605-357-1439 • 800-658-3080 (V/TTY) • www.usd.edu/cd

Clinic Referral Form

Services Requested: _____Autism Spectrum Disorder Clinic
_____Fetal Alcohol Spectrum Disorders Clinic
_____LEND Developmental Clinic

Please answer the following questions **with regard to the individual being referred**.

Individual and Family Information

Individual's Name _____

Date of Birth _____ Age* _____

***Note: If individual being referred is 18 or older, please see note on p. 4.**

Race/Ethnicity_____ Hispanic Yes or No ☐ Female ☐ Male

Family Information

	Mother	Father
Name:		
Relationship:	___Mother ___Step-mother ___Legal guardian ____Foster Parent ___Other:_____	___Father ___Step-father ___Legal guardian ____Foster Parent ___Other:_____
Address:		
Home Phone:		
Cell Phone:		
*Work:		
*Email:		

*If it is ok to call you at work and/or to email you to schedule requested services, please provide work number and email address.

If Mailing Address is PO Box, please provide physical address: _____
With whom does the individual being referred live?_____

Has guardianship or custody been established for the individual through the courts? Yes No
If yes, please provide copy of current guardianship papers or custody decree.

Is there another parent or legal custodian who is involved in the individual's life and who may need to consent to requested services or receive copies of reports? **Yes No**

If yes, please provide the following information:
Name: _____
Relationship to individual:_____
Mailing address:_____

School/Agency Information

School District/Agency Name_____

Attendance Center _____

Individual's Grade/Program _____

Attendance Center/
Agency Address_____
(Mailing Address) (City/State) (Zip Code)

Physical address, if different from mailing address: _____

Phone: _____ Fax: _____

Please list the name of the person we should contact at the school/agency to arrange the requested services and mail copies of reports to:

Contact Person _____

Position_____

Phone_____

E-mail _____

Location/address: _____

Reason for Referral: _____

_____

_____

_____

Payment of Services: See Purchase of Service form.

Presenting Concerns (Please complete those that are relevant to the individual being referred.)

Academic/Vocational Skills _____

Behavioral _____

Communication/Hearing _____

Medical _____

Motor (gross and fine) _____

Social _____

Other _____

Please list any **medications, vitamins or supplements** the individual is currently taking and the dosage(s).

Current/Previous Diagnoses	Date Diagnosis Made	Diagnosing Doctor or Clinician* *Please include them on Release of Information form.

What **educational/vocational programming** is in place for this individual? _____
_____
_____

What **strategies** have you found to be the most helpful when working with this individual? _____
_____
_____

Has this individual been **seen previously by Center for Disabilities** personnel (programs include Autism Spectrum Disorder, Deaf-Blind, Birth to 3, Fetal Alcohol Syndrome Disorders, LEND Developmental Clinic)?
Yes ___ No ___
If yes: Individual was seen on _____(date) by _____ Program.

Please make sure that the school/agency is listed on the Authorization for Release of Information form, along with any agencies/therapists who have done testing or made diagnoses of the individual being referred.

_____ _____
Signature of Person Completing This Form Date

_____ _____
Signature of Parent/Legal Guardian* Date

***If individual being referred is 18 years old or older, he/she must sign the Informed Consent Form and the Authorization for Release of Information him/herself unless guardianship has been established by the parent or another individual. If guardianship has been established, please include a copy of the guardianship papers.**

If you have a disability and require special accommodations in order to participate in this clinic/consult, please describe the requested accommodation below. Requests for accommodations must be received two weeks prior to the clinic/consult. _____

_____