**Therapeutic Early Autism Program of WBH/UPMC**
**REFERRAL FORM**
**2400 East Carson Street Pittsburgh, PA 15203**
**Phone: 412.310.9478 Fax: 412.431.1824**
**Questions? Call Carine VanBuren 412.713.0855 or email TEAP@upmc.edu**

***Please fill out form entirely.***

## *Demographic Information*

| | |
|---|---|
| **Child's Name:** | **Gender:** |
| **Child's Birth date: _____**<br><br>**Age:_____** | **Medical Assistance Number:**<br>**_____**<br>**☐ Application submitted, number pending** |
| **Residence (Parents, Grandparents, Foster Home, other living arrangement)**<br>**_____** | **Last four digits of Social Security Number:** |
| **Parent(s)/Guardian Name:** | |
| **Address:** | **Phone Number:**<br>**_____**<br>**Additional Number:**<br>**_____** |
| **Preferred Language for Parent:** | **Child:** |

**Are there any cultural, language, or religious considerations you would like us to know to aid/improve treatment for your child and family?**

**When calling, may we leave a message at the above number(s) identifying our program?**

**☐ Yes ☐No Comments:**

## *Family Information*

**Household Members (Name/Relation to child/Age):**

**Others Involved in Direct Care of Child (Name/Relation to child/Age)**

## *Health Information*

**Is your child taking any medications? ☐ Yes ☐ No**

| Medication | Dosage | Prescribing Doctor |
|---|---|---|
| | | |
| | | |

**Significant Medical Conditions and/or Allergies: ☐ Yes ☐ No**

**Describe:**_____

_____

**Primary Care Physician/Pediatrician (Doctor/Practice)** _____

_____

**Address:**_____

**Phone:**_____

## *Diagnostic Information*

**Please provide your child's current diagnoses:**

**Behavioral Health Diagnosis:** _____

**Behavioral Health Diagnosis:** _____

**Behavioral Health Diagnosis:** _____

**Medical Conditions/Physical Health Issues (if applicable):** _____

**Date of most recent psychological evaluation:** _____

***If you have a copy of a psychological evaluation, please feel free to include***

## *Additional Insurance Information*

***Does your child have any insurance coverage in additional to Medicaid (Medical Assistance)? For example, insurance through your employer. If so, please provide those details below.***

**Primary (Commercial) Insurance Information: Provide information below or ☐ N/A**

| |
|---|
| **Insurance Provider Name:** |
| **ID Number:** |
| **Group Number:** |
| **Insurance Holder (Subscriber) Name:** |
| **Subscriber's DOB:** |
| **Insurance Phone Number:** |
| **Renewal Date:** |

## *Clinical and Behavioral Information*

**Communication Skills (Describe how your child typically communicates their wants and needs):**

_____

_____

_____

_____

_____

_____

**Does your child use any non-vocal methods of communication?** (sign language, AAC, pulling adult to item, pointing, etc.) ☐ Yes ☐ No **Describe:**

_____
_____
_____
_____
_____

**Aggression to Others** (hitting, kicking, biting, hair pulling, etc.) ☐ Yes ☐ No
**Describe:**

_____
_____
_____
_____

**Self-Injurious Behaviors** (hitting, banging head, biting, etc.) ☐ Yes ☐ No
**Describe:**

_____
_____
_____

**Tantrums** (intense crying/screaming, flopping to the floor, etc.) ☐ Yes ☐ No
**Describe:**

_____
_____
_____
_____

**Safety Concerns** (eloping/running away; unbuckling car seat, no stranger danger etc.) ☐ Yes ☐ No
**Describe:**

_____
_____
_____
_____

**Fears/Anxiety** (animals, going to new places, loud noises, etc.) ☐ Yes ☐ No
**Describe:**

_____
_____
_____
_____

**Oppositional** (refusal to follow instructions, argumentative, etc.) ☐ Yes ☐ No
**Describe:**

_____
_____
_____

**Intense Interests** (focus on specific topics or objects, repeating lines from videos/TV shows, play with only certain types of toys) ☐ Yes ☐ No
**Describe:**

_____
_____
_____

**Stereotypical Behaviors** (hand flapping, rocking, looking at items from different angles, lining things up, spinning objects etc.) ☐ Yes ☐ No
**Describe:**

_____
_____
_____

Social Skills/Difficulties interacting with peers (difficulty sharing toys, avoidance of peers, limited eye contact, does not respond to peers, etc.) ☐ Yes ☐ No
**Describe (please describe positive social skills as well):**

_____
_____
_____

**Does your child have difficulty separating from anyone in the family and/or does anyone in family have difficulty separating from child?** ☐ Yes ☐ No
**Describe:**

_____
_____
_____

**Other Behavioral Concerns/Issues not noted above Describe:**

_____
_____
_____

## *Overall Health and Self-Care*

**Feeding/Eating Concerns (limited diet, food intolerance, doesn't feed self with utensils, etc.)** ☐ Yes ☐ No
**Describe:**

_____
_____

**Food allergies** ☐ Yes ☐ No
**Describe:**

_____
_____
_____

**Sleep Issues/Concerns** (taking a long time to fall asleep, waking up multiple times a night, etc.)
☐ Yes ☐ No **Describe** (please note whether or not your child naps):

_____
_____

**Toileting/Potty Training (use of pull ups/diapers, constipation/diarrhea issues, any potty training attempts)**
**Describe:**

_____
_____
_____
_____

**CYF/Child Protective Services Involvement: ☐ Yes ☐ No**
**Describe:**

_____
_____

## *Child and Family Strengths*

**Child:**_____
_____
_____
**Family:**_____
_____
_____

## *Family Resources*

**1) How do you get to store/appointments, etc.?**

☐ **Own Car** ☐ **Bus/public transportation** ☐ **Rely on friends/family** ☐ **Uber/Lyft**

**Comments:**_____

**2) If you need someone to watch your child when you need to go somewhere, is that:**

☐ **Possible** ☐ **Possible, but challenging** ☐ **Very difficult** ☐ **Not an option**

**Comments:**_____

**3) Is your child available to attend TEAP from 8:30 AM – 2:30 PM Monday- Friday?**

☐ **Yes** ☐ **No**

**Comments:**_____

**4) Are you or another adult able to provide transportation to and from TEAP every day?**

☐ **Yes** ☐ **No**

**Comments:**_____

## CURRENT SERVICES AND SERVICE HISTORY

| SERVICES RECEIVED | PROVIDER/AGENCY | CONTACT PERSON/ PHONE NUMBER | SERVICE DATES |
|---|---|---|---|
| **Service Coordination / Case Management**<br><br>(examples include Pittsburgh Mercy, Pressley Ridge, HSAO, Staunton Clinic) | | | |
| **Outpatient Therapy**<br><br>(include outpatient speech, OT, PT, etc.) | | | |
| **IBHS (Intensive Behavioral Health Services)** | | | |
| **IEP/School services**<br>(AIU or Pittsburgh Public)<br><br>☐ Occupational Therapy<br>☐ Physical Therapy<br>☐ Speech<br>☐ Itinerant/Developmental | | | |
| **Daycare/Childcare** | | | |
| **Other (include anything not listed above** | | | |

**Other comments/information not noted above that you would like to share with us:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Thank you for taking the time to completely fill out this information. It is appreciated and helpful in determining what level of service would most benefit your child.**