CFS Specialized Services Referral Form

Collaborative Care Team

AUTISM PROGRAM

Date of Referral: _____

Email Referrals: autism@mhmrtc.org & Samantha.Sneed@mhmrtc.org

Must Reside in Tarrant County

Child Referral Information

First Name		Last Name:		Middle Initial:	Select
DOB:		Chronological Age:		Gender:	Select
Language:	Select	Other:		Interpreter?	No
Name of Insurance:			Policy Holder Name:		
Insurance ID#:			Insurance Group #:		

Parent / Guardian Information

First Name:				Last Name:			
Address:		Apt. #		City:		TX.	Zip:
Phone #:				Preferred method of Contact:	Select		
Permission to Text:	Select			Best Time to Call:	Select		Selec
Email Address:							

First Name:				Last Name:			
Address:		Apt. #		City:		TX.	Zip:
Phone #:				Preferred method of Contact:	Select		
Permission to Text:	Select			Best Time to Call:	Select		Select
Email Address:							

Reason for Referral

Complex Diagnostic Assessment

Person Making Referral

First Name:		Last Name:	
Phone #:		Email:	
Program / Agency Name:			

Referral Type: Select

****** If applicable, please include the following with submission of referral******

1. **Medical paperwork for all current IDD, Autism, or Mental Health Diagnosis.**
2. **School, IEP's / assessments (if applicable)**
3. **Date of last Autism Diagnosis: _____**