The Autism Center at the University of Louisiana at Monroe

Speech-Language Pathology and Occupational Therapy Programs

School of Health Professions, College of Health and Pharmaceutical Sciences

Dear Parent/Guardian:

The professionals and staff at the Autism Center at the University of Louisiana at Monroe (AC-ULM) would like to thank you for your recent request for information regarding information for your child. Enclosed you will find information to be completed and returned to the AC-ULM. This information will be used in determining potential evaluations and services for your family.

The following information is needed for your packet to be considered:

1. All of the enclosed forms must be completed entirely. **Incomplete packets will not be considered by the AC-ULM Team.**
2. Copies of any previous evaluations (if applicable).
3. Current Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) (if applicable).
4. Provide proof of custody (if custody has been established by a court of law).

After all requested information is received, your child's needs will be discussed at a staff meeting. ***You will be contacted after this meeting to discuss the faculty's recommendations.*** If you have any questions, please contact Dr. David Irwin, Director, at 318.342.3190. Additional information can be found on our website at www.ulm.edu/autismcenter

DO NOT FAX the attached forms, only originals are accepted. Please forward the requested information to:

Autism Center at University of Louisiana at Monroe

Attn: Dr. David Irwin, Sugar Hall Room 104

Monroe, LA 71209-0321 Phone 318.342.3190

Print and complete the Referral for Evaluation and Reason for Referral Forms

The Autism Center at the University of Louisiana at Monroe
A Cooperative Program with Speech-Language Pathology and Occupational Therapy Programs
104 Sugar Hall, 700 University Avenue, Monroe, LA 71209-0321
318.342.3190 website: www.ulm.edu/autismcenter

REFERRAL FOR EVALUATION

Child's name: ____ Age: _______

Date of Birth: ___________________________ Race: ______________ Sex: _______________

Address: ____

City, State, Zip ____ Parish: __________________

Social Security Number: ____________________ Emergency Contact #: ____________________

Child lives with & relation to child: ___________________Current School: ___________________

Child's Pediatrician: _______________ Phone_________________ City/State_______________

Father: Name: ____

Educational Level: _________________________________ Occupation: ____________________

Place of Employment: ____

Phone: (Cell): __________________________________ (Work): _________________________

Mother: Name: ____

Educational Level: _________________________________ Occupation: ____________________

Place of Employment: ____

Phone: (Cell):_____________________________ (Work): _____________________________

Other siblings living in the home:

Name: _______________________ Date of birth: _______________ Relationship ___________
Name: _______________________ Date of birth: _______________ Relationship ___________
Name: _______________________ Date of birth: _______________ Relationship ___________

****

Referral Source: _____ School ______ Primary Care Physician ______ Parents ____ Other _________
Person Making Referral: ____
Relationship to child/position: ____
Address: ____ Phone: ____________________
City ____ State ________ Zip ______________
Previously Seen at the Autism Center at ULM? Yes ____: Date ____________________ No ________
Type of Evaluations Requested: _______ Autism Diagnostic Evaluation _______ Feeding Evaluation
______ Executive Function Evaluation _______ Augmentative/Alternative Communication Evaluation

REASON FOR REFERRAL

What do you hope to learn as a result of this evaluation? ______________________________________
____
____

Briefly describe any academic/learning problems: ____
____
____

Briefly describe any behavioral/emotional problems: ____
____
____

Briefly describe any speech/language/hearing problems: ____________________________________
____
____

Briefly describe any health or medical problems: ____
____
____

Briefly describe any gross/fine motor problems: ____
____
____

Other problems or areas of concern: ____
____
____

Previously diagnosed with Autism Spectrum Disorder? _____ Yes ____ No
Name of Facility? ____

Person Who Made the Diagnosis? ____

Date of Diagnosis? _______________________________ **Child's Age:** _________________________

Address: ____

City, State, Zip ____

Phone: ____ **Fax:** ____________________________

+++

This form is being completed by: ____

Signature: ____**Date Completed** _________________

Relationship to Child ____________________________**Who has custody of this child?** ___________

Questions? Contact Dr. David Irwin, CCC-SLP, Director of the Autism Center at ULM, 318.342.3190