Primary Care Physician Request for Autism Diagnostic Evaluation through Phoenix Children's

Please note: *This questionnaire must be completed for the patient's request for evaluation to be considered.*

Subspecialty Physicians: *If you are a subspecialty provider, please send the patient back to their PCP with your concerns and recommendation documented. The PCP can then place the appropriate request.*

Patient Information	
Patient Name:	Date of Birth:
Parent(s)/Guardian(s) Name:	

Professional Information	
Referring Physician Name:	
Agency Name:	
Position:	
Phone Number:	Fax Number:
Email Address:	
Mailing Address:	

Services requested/Recommended – please select only one:	
☐	Child needs a medical diagnostic evaluation for autism spectrum disorder
☐	Child has a confirmed autism spectrum disorder diagnosis by a DDD approved provider (educational diagnosis of autism does not count) and needs management with a developmental pediatrician

Existing Diagnoses along with available documentation and diagnostic reports

Diagnosis	Date of Diagnosis	Diagnosis managed by	Documentation and diagnostic reports included (check for yes)
			☐
			☐
			☐

Is this patient considered medically complex (i.e., diagnosed with genetic disorder or 2 or more medical diagnoses)? ☐ Yes ☐ No

Is this patient hard of hearing, deaf, or blind? ☐ Yes ☐ No

Please state primary concern for the patient:

Autism Diagnostic Evaluation Referral

Symptoms associated with autism spectrum disorder: Please check the symptoms below that apply to this patient.

Communication (e.g., receptive and expressive language):	
☐	Delayed speech
☐	Only communicates to get needs met
☐	Does not point or respond to pointing
Social and Emotional Relatedness:	
☐	Does not make or avoids making eye contact (check if infrequent or atypically intense)
☐	Does not point at objects to show interest
☐	Does not respond to their name
☐	Prefers to play alone
☐	Does not look at objects when caregivers attempt to show something exciting
☐	Has a hard time making and keeping friends, but would like friends (not due to social fears)
☐	Does not seem to understand social norms or nuances

Restricted Interests and Repetitive Behaviors (include unusual preoccupations, rituals, routines, or sensory interests):	
☐	Repeats the same phrases over and over
☐	Echoes the speech of others
☐	Lines up toys or other objects
☐	Has obsessive interests/routines
☐	Smells things without obvious odor
☐	Licks or mouths things without obvious flavor
☐	Gets upset by minor changes
☐	Overreacts to certain sounds
☐	Play with toys the same way each time
☐	Does not play “pretend” games (e.g., “feed” a doll or talk on the “phone”)

Other behaviors (e.g., tantrums, self-injurious behaviors):	
☐	Engages in self-injurious behaviors (e.g., biting or hitting oneself, headbanging)
☐	Has tantrums that appear to be atypical for developmental age

Please describe additional behaviors that you feel warrant an autism spectrum disorder diagnostic evaluation. Please be as specific as possible.

At what level is the physician’s suspicion of autism spectrum disorder (check one)?

☐	Low	☐	Medium	☐	High

Does the physician suspect or is there known developmental delay or intellectual disability for this patient?

☐	Yes, specify:
☐	No

Is the family aware of the reason for this recommendation?

☐	Yes
☐	No, specify:

Autism Diagnostic Evaluation Referral

Please add anything else you think we should know about this child and/or family (e.g., languages spoken at home, child uses augmentative alternative communication device)**:**

****Please attach all documentation pertaining to concern for autism (not just the last well-child visit) as well as any current or historical M-CHAT-R assessments.** Please note that M-CHAT-R assessment is required for recommendations for patients under 3 years.

While your patient waits to hear from us, we have a few requests of you:

1. **If the patient has not yet had their hearing checked, please refer for an audiology evaluation.**
2. **If the patient has not yet started therapies, please consider referrals to appropriate therapies (e.g., speech, occupational).**

Physician Signature: **Date:** **Time:**

Physician Printed Name: