WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

Autism Program Referral Form

Patient Contact Information

Patient Name: _____ DOB: _____
Street Address: _____ Gender: _____
City: _____ State: _____ Zip Code: _____

Parent/Guardian Name(s): _____ Phone: _____
Insurance Company: _____ Member Number: _____
Group Number: _____ Subscriber Name: _____ DOB: _____

Services Requested (Check all that apply)

	Service	*Description*	*Requirements*
☐	Diagnostic Testing	Testing to determine if patient meets DSM-5 criteria for Autism, or to reevaluate if previous testing occurred more than 3 years ago.	We are currently unable to accept OHP-Healthshare or Molina (WA only).
☐	Applied Behavior Analysis (ABA)	Our most intensive service for patients with significant difficulties communicating, behavior problems, or social skill deficits.	Patient must have current diagnosis of Autism Spectrum Disorder and be within the ages of 2.5-17 years old. We are currently unable to accept OHP or Molina (WA only).
☐	Mental Health Treatment	Traditional mental health therapy for patients with Autism Spectrum Disorder and comorbid depression, anxiety, ADHD, etc.	Ages and specialties vary by location.
☐	Social Skills Group	Groups utilize evidence-based PEERS curriculum.	Groups run once there are enough participants in an age group. Parent participation required.

Referring Provider Information

Name: _____ Clinic: _____
City, State: _____
Phone: _____ Fax: _____

Office Contact (if not referring provider): _____

Please fax completed form to 503-233-2694

For office use only: Date request received _____ Received by _____
Request Approved (If no, give reason) ☐ Yes ☐ No _____
_____