FSU Center for Autism and Related Disabilities
Referral/Intake (Adult with Guardianship)

All of CARD services are FREE of charge. Please fill out this referral packet as completely as possible and return in the enclosed envelope. You will be contacted by CARD staff when your referral packet has been received in our office. Please print in ink.

Date: ______________________________

Client Name: ______________________________

Date of Birth: ______________ Male/Female ______________ Ethnicity ______________

Client Address: ______________________________

City, State, Zip: ______________________________

E-Mail: ______________________________

County: __________ Phone: (H): ______________ (W): ______________ Cell: ______________

Parent(s)/Guardian(s) ______________________________

PLEASE INCLUDE GUARDIANSHIP DOCUMENTATION

Parent/Guardian Address (if different from above): ______________________________

City, State, Zip: ______________________________

E-Mail: ______________________________

County: __________ Phone: (H): ______________ (W): ______________ Cell: ______________

May we leave a voice message? __________ If so, which number(s)? ______________________

Diagnosis: ______________________ By Whom: ______________ Date: __________

INCLUDE COPY OF EVALUATION REPORT DOCUMENTING DIAGNOSIS

FSU Center for Autism and Related Disabilities
625-B North Adams, Tallahassee, Fl 32301
(800) 769-7926/ (850) 644-4367
(850) 644-3644 – Facsimile

5192 Bayou Boulevard, Pensacola, FL 32503
(850) 484-5040, ext. 1326
(850) 494-5783 – Facsimile

2611-A West 23rd Street, Panama City, FL 32405
(866) 863-0138/ (850) 215-4330
(850) 215-4337 – Facsimile

Rev. 1/3/08

FSU Center for Autism and Related Disabilities Referral/Intake (Continued)

Other Health Concerns: ____

____

Medications: ____

Place of Employment (if applicable): ____________________ Contact: ____________________

Address: ____

City, State, Zip: ____________________ Phone: ____________________

Name of School (if applicable): ____

Address: ____

City, State, Zip: ____________________ Phone: ____________________

Other Agencies/Service Providers: ____

Who referred you to CARD? ____

Name/Title ____________________

Agency ____________________

Mailing Address ____

Phone ____________________

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Crisis Screening

1. Is the referred individual in danger of injuring self or others?

2. Has the referred individual injured self or others? In what manner? Is it likely to continue?

3. Has property been damaged or destroyed and is it likely to continue?

4. Has/will this person's behavior interfere with their ability to remain and participate in their classroom/home/community?

Additional notes:

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Profile

1. How does the referral individual communicate? (Check the one he/she uses most often)

____ Vocalizations
____ Single words
____ Two or three word phrases
____ Sentences
____ Sign Language/Gestures
____ Pictures
____ Communication Device
____ Other

2. How does he/she let you know his/her:

   Wants/Needs?

   When he/she needs help?

   When he/she doesn't like something?

3. How do you provide information to him/her? (Check all that apply)

   ___ Objects ___ Pictures ___Gestures ___Verbal
   ___ Visual Schedules ___Social Stories ___ Other

   Describe: ____
   ____
   ____

4. List some things he/she does well:

5. List some things that help him/her stay calm:

6. What are some of his/her favorite things, toys or characters? What are his/her interests?

7. List things or events that he/she doesn't like or finds difficult:

8. What are your concerns about him/her at this time?

FSU Center for Autism and Related Disabilities Permission to Observe & Exchange Information

I hereby authorize & request the Florida State University Center for Autism and Related Disabilities permission to observe CARD client, ____.

I hereby authorize & request the Florida State University Center for Autism and Related Disabilities permission to exchange information about the CARD client listed above with the **school, agencies, and individuals** listed below. I also grant the agencies listed below permission to exchange information and release educational, medical, psychological, psychiatric, or other records to the Florida State University Center for Autism and Related Disabilities.

Please list below individuals and agencies with whom CARD may exchange information:

School(s)/Work Site:

____ ____

____ ____

Doctor(s):

____ ____

____ ____

Other agencies/therapists/specialists:

____ ____

____ ____

Other family members:

____ ____

____ ____

____ ____

(Guardian signature) (Date)

____ ____

(Signature of Adult Client if 18 or older) (Date)

I understand that I may revoke this authorization at any time.

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