



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



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.

Date: _____

Name: _____

Date of Birth: _____ Male/Female _____ Ethnicity _____

Address: _____

City, State, Zip: _____

Phone: (H): _____ (W): _____ Cell: _____

E-Mail: _____

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

Diagnosis: _____ By Whom: _____ Date: _____

*****INCLUDE COPY OF EVALUATION REPORT DOCUMENTING DIAGNOSIS*****

Other Health Concerns: _____

Medications: _____

Place of Employment: _____

Address: _____

City, State, Zip: _____

Phone: _____

FSU Center for Autism and Related Disabilities
625-B North Adams, Tallahassee, FL 32301 Fax

(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

Other Agencies/Service Providers: _____

Insurance: _____

Name of School (if applicable): _____

Address: _____

City, State, Zip: _____ Phone: _____

Were you referred to CARD? If so, by whom? _____

Name/Title _____ Agency _____

Mailing Address _____

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**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 exchange information about, _____, CARD client, 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)/Community Agencies/Work Sites:

Doctor(s):

Other agencies/therapists/specialists:

Other family members:

(Signature of Individual)

(Date)

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

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