



**FSU Center for Autism and Related Disabilities
Referral/Intake**



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 _____

Parent(s)/Guardian: _____

E-Mail: _____

Address: _____

City, State, Zip: _____

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

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

Parent (if different): _____

E-mail: _____

Address (if different): _____

City, State, Zip: _____

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

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

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

(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



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



Diagnosis: _____ By Whom: _____ Date: _____

*****PLEASE SEND COPY OF DIAGNOSTIC EVALUATION/DIAGNOSIS*****

Other Health Concerns: _____

Medications: _____

School Name: _____ Teacher/School Contact: _____

Type of Class: _____ Grade: _____

School Therapy Services: _____

Other Therapy Services/Agencies: _____

What are your primary concerns? _____

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 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)/County School Systems:

Doctor(s):

Other agencies/therapists/specialists:

Other family members:

Was your child ever a client of the FIRST WORDS Project? YES NO

Do you give consent to share information? YES NO

(Signature of Legal Guardian or Adult Client if 18 or older)

(Date)

I understand that I may revoke this authorization at any time

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