CORNERSTONE AUTISM CENTER

380 Polk Street | Greenwood, IN 46143
PH 317.888.1557 | FX 317.888.1571

Physician Referral / Questionnaire for Diagnostic Evaluation

Today's Date _____/_____/_____

Physician Name: _____ Office Name:_____

Address: _____ Phone: _____ Fax: _____

Parent/Guardian Contact

Name _____ Phone: _____ Email: _____

Child Information

Child's Name _____ DOB ____/_____/_____ Age: _____ Sex: M F

Reason for Referral:_____

Please check areas of concern:

- □ Cognitive / Intellectual Functioning
- □ Academic Abilities and Functioning
- □ Speech and Language Development
- □ Social Development
- □ Emotional Development
- □ Behavioral Functioning
- □ Adaptive Functioning
- □ Not meeting developmental milestones

Has the child been diagnosed with any of the following, please explain:

- □ Genetic Disorder: _____
- □ Metabolic Disorder: _____
- □ Seizure Disorder: _____
- □ Congenital Disorder: _____
- □ Other Medical Illness/ Disorder: _____

Current Medications:_____

_____

Recommended Interventions

- □ ABA Therapy, 35 hours per week _____
- □ BCABA Supervision, determined by Cornerstone Clinical Staff _____
- □ Occupational Therapy, provided by Dr. Rachel Timmons OTD, OTR/L
- □ Speech/Language Therapy, provided by Dr. Robert Kurtz PhD, CCC-SLP

Physician Signature: _____ Date: _____

Please attach any pertinent information regarding birth history, illnesses, or medical concerns.