Skagit Multidisciplinary Autism Review Team
Child Intake Form

Referral Date	Referred by		
Child's Name	Birthdate	Age	☐ M ☐ F
Parent/Caregiver	Address		
Primary Phone	Secondary Phone		
E-mail	Primary Language:	Interpreter Needed? ☐ Yes ☐ No	

Insurance Information

Apple Health: ☐ Amerigroup ☐ Community Health Plan of Washington ☐ Coordinated Care ☐ Molina	
Provider One number	
Private Insurance Provider	Subscriber Name
Group #	ID#

Medical Information

Provider	Name and contact info
☐ Primary Care Provider	
☐ Speech/Language	
☐ OT	
☐ PT	
☐ Early Intervention Provider	
☐ School District	
☐ Other specialty provider	

Screening/Evaluations Conducted

Are you on a waitlist for any evaluations or service? If so, where and when were you placed on the list?

Observation Checklists: ☐ Parent ☐ Child Care ☐ Teacher ☐ Medical ☐ Psych ☐ OT ☐ PT ☐ Speech ☐ Other

Screening/Evaluation	Provider	Date	Requested	Received	Notes
Hearing					
ASQ/ASQ S-E					
Speech/Language					
Social-Emotional					
Cognitive					
M-CHAT (16-30 mo)					
STAT (24-36 mo)					
ADOS					
ESIT Records/IFSP					
School Records/IEP					

HIPPA Forms: ☐ SPARC ___/___/___ ☐ SCPH ___/___/___

Date intake complete: