

School Medical Autism Review Team Demographics Form

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| Referral Date: | Person Referring: Click here to enter text. |
| Child’s Name: Click here to enter text. | Child’s Date of Birth: Click here to enter text. |
| Child’s Primary Language: Click here to enter text. | |

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| Parent/Guardian Name: Click here to enter text. | Relationship to Child: Click here to enter text. |
| Mailing Address: | Primary Language: Click here to enter text. |
| Primary Phone: Click here to enter text. | Secondary Phone: Click here to enter text. |
| Email Address: Click here to enter text. | Preferred Mode of Contact: Click here to enter text. |

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| Primary Insurance: Click here to enter text. | Group #: Click here to enter text. |
| PCP Clinic Name: Click here to enter text. | Member ID # : Click here to enter text. |
| Primary Doctor: Click here to enter text. |  |

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| Primary Care Provider: Dr Dana Peterson | School/Daycare: Click here to enter text. |
| Birth to Three: Click here to enter text. | Occupational Therapy: Click here to enter text. |
| Physical Therapy: Click here to enter text. | Speech and Language Therapy: Click here to enter text. |
| Mental Health: Click here to enter text. | Other: Click here to enter text. |