

## San Juan Multidisciplinary Autism Review Team Child Intake Form

Referral Date	Referred by		
Child's Name	Birthdate	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Parent/Caregiver	Address		
Primary Phone	Secondary Phone		
E-mail	Primary Language:	Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Insurance Information

<b>Apple Health:</b> <input type="checkbox"/> Amerigroup <input type="checkbox"/> Community Health Plan of Washington <input type="checkbox"/> Coordinated Care <input type="checkbox"/> Molina	
<b>Provider One number</b>	
<b>Private Insurance Provider</b>	Subscriber Name
Group #	ID#

### Medical Information

Provider	Name and contact info
<input type="checkbox"/> Primary Care Provider	
<input type="checkbox"/> Speech/Language	
<input type="checkbox"/> OT	
<input type="checkbox"/> PT	
<input type="checkbox"/> Early Intervention Provider	
<input type="checkbox"/> School District	
<input type="checkbox"/> 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/ Primary Care  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					
Other:					