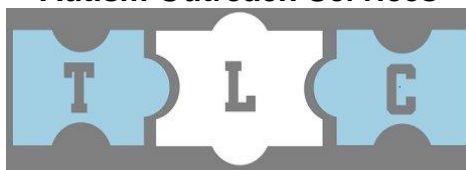


Treatment & Learning Center for Children with Autism  
and  
Autism Outreach Services



OFFICE: 903-593-4004 FAX: 903-593-4121

DATE: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Child lives with:  Mother & Father  Mother  Father

Other/Legal Guardian (please specify): \_\_\_\_\_  
\*\*\*guardianship papers must accompany application

Primary language spoken in the home: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone Number (home): \_\_\_\_\_ (work): \_\_\_\_\_

Referring Person/Title: \_\_\_\_\_ Referring Agency \_\_\_\_\_

Phone Number: \_\_\_\_\_

School youth attends: \_\_\_\_\_

Grade: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

AC DMR or endorsement date: \_\_\_\_\_

Attachments: (please check and attach the following forms)

- Medical History
- Diagnosis of mental retardation or autism assessment (DMR)
- Psychological testing or assessment
- Individual Education Plan (IEP)
- Full Individual Evaluation (FIE)
- Any additional relevant forms or information

Date of Parent/Guardian consent for referral to Andrews Center:

Obtained from: \_\_\_\_\_ parent  guardian

Date obtained: \_\_\_\_\_

Describe current behaviors/Reason for referral;

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Representative of Referring school or agency