



Autism and Asperger's Outreach

OFFICE: 903-597-1351 FAX: 903-535-7388

DATE: _____

Youth's Name: _____

DOB: _____

Parent/Guardian: _____

Relationship: _____

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)

Diagnosis of mental retardation assessment (DMR)

Psychological testing or assessment

Individual Education Plan (IEP)

Full Individual Evaluation (FIE)

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