School Medical Autism Review Team Demographics Form

DATE OF REFERRAL: ___/_____/_____ **PERSON REFERRING:** _____

CHILD'S NAME: _____ **DOB:** _____/_____/_____

PARENT/GUARDIAN(S): _____

RELATIONSHIP TO CHILD: _____

MAILING ADDRESS: _____ **CITY:** _____, **WA ZIP:** _____

PRIMARY PHONE: (____) _____ **ALTERNATE PHONE:** (____) _____

INSURANCE: _____

SCHOOL/ DAYCARE/ BIRTH TO THREE: _____

_____

CURRENT TEACHER: _____

CURRENT LOCATION: _____

CURRENT OCCUPATIONAL THERAPIST: _____

CURRENT LOCATION: _____

CURRENT PHYSICAL THERAPIST: _____

CURRENT LOCATION: _____

CURRENT SPEECH LANGUAGE THERAPIST: _____

CURRENT LOCATION: _____