|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Information** | | | | | |
| Child’s Name |  | Date of Birth |  | Gender |  |
| Street  Address |  | City, State & Zip |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Caregiver Information (please only include individuals who will be involved with services) | | | |
| Caregiver #1 Full Name |  | Caregiver #2  Full Name |  |
| Street  Address |  | City, State & Zip |  |
| Phone Number |  | Additional Phone |  |
| Email #1 |  | Email #2 |  |
| Is this person the child’s legal guardian? ☐ Yes ☐ No ☐ Unsure | | | |
| Does family need an interpreter? ☐ Yes ☐ No Language spoken: | | | |
| Best Day(s) and Time(s) to Contact: | | | |
| Has Parent/Caregiver expressed interest in services? ☐ Yes ☐ No If no, explain: | | | |

|  |  |
| --- | --- |
| **M-CHAT SCORE**  *(circle one)*  0-2 3-7 8+  if 3-7 please list items #s  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Reason for Referral: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Which of our offered services have you discussed with the client?**

☐ Family Navigation only (resources and services for child with prior ASD diagnosis)

☐ Diagnostic Evaluation for Autism Spectrum Disorder ☐ Child Mental Health Therapy (ages 2-7)

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Agency Information *(please leave blank if you are the child’s parent/caregiver)* | | | |
| Name of Person Completing Form | Referral Date | Relationship to Child | Office Number |
|  |  |  |  |
| Agency Name | Agency Fax | Email Address | Cell Number |
|  |  |  |  |

☐ Other: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ 8-Week Parent/Caregiver Support Program

Completed referrals should be emailed with a signed Consent for Release of Information to [help@nextstepclinic.org](mailto:help@nextstepclinic.org) or if email unavailable faxed to 414-488-0057. Email is preferred. Once a referral is received, it is reviewed by our Clinical Team and assigned to one of our Family Navigators, who will then contact the family to initiate intake for services.