Embodied Heart Space

AUTISM EVALUATIONS & INTEGRATIVE THERAPIES

PROVIDER REFERRAL FORM: 1.5 to 4.11 YEARS OLD

Dr. Michele Iemolo requires a referral from a healthcare provider **who has an individual Medicaid number**, for all autism evaluations. This form is to be completed by the licensed provider who is currently treating the client. Autism evaluations are only offered in **English** for children **1.5 to 4.11 years old.**

Please make sure to complete all fields and fax to (505) 212-4412. Or you can complete this form online: https://intakeq.com/new/xs8bzs

CHILD/CLIENT INFORMATION

Date: _____ Primary Insurance_____

Child's First Name: _____ Child's Last Name: _____

Child's Date of Birth: _____ Child's Gender: _____

PARENT/CAREGIVER INFORMATION

Parent/Caregiver First Name: _____ Last Name: _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

REFERRING HEALTHCARE PROVIDER INFORMATION

Licensed Healthcare Provider Full Name: _____

Practice Name: _____ **Individual Medicaid Number:** _____

Provider Phone: _____ Provider Email: _____

Fax this form to: (505) 212-4412

3415 Carlisle Blvd NE Albuquerque, NM 87110
Phone: (505) 420-1814 www.EmbodiedHeartSpace.com

Address: _____

City: _____ State: _____ Zip: _____

Provider Type: (Must have an individual Medicaid Number)

- ☐ Pediatrician
- ☐ PCP
- ☐ CNP
- ☐ Psychologist
- ☐ Speech-Language Pathologist
- ☐ Occupational Therapist
- ☐ Social Worker
- ☐ Mental Health Counselor
- ☐ Early Intervention/FIT Provider
- ☐ Other: _____

REQUIRED SCREENING

Please complete and attach one of the required screeners related to autism spectrum disorder.

- ☐ Modified Checklist for Autism in Toddlers Revised with Follow-up (M-CHAT-R/F)
- ☐ Social Communication Questionnaire (SCQ)
- ☐ Social Responsiveness Scale-2nd Ed (SRS-2)
- ☐ Survey of Wellbeing of Young Children (SWYC)
- ☐ Other Screening:

(Needs to be a screener with a score. **A provider letter or note will not suffice**): _____

Date Screening Was Completed: _____

What were the results of the screening? (Medium Risk/High Risk): _____

Please describe any developmental delay(s) and/or differences including manifestation of ASD characteristics (i.e., impairment in social communication, presence of restricted, repetitive, stereotyped patterns of behavior) or behavioral concerns that suggest need for further evaluation.

☐ I certify that I am the child's healthcare provider **with an individual Medicaid Number** completing this form.

Print Name: _____

Signature: _____ Date: _____

Please fax this form along with the screener evaluation to 505-212-4412. Thank you.

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