To: Primary Care Provider _____

Child's name: _____ **D.O.B.** _____
Was referred to: The _____ (insert team) Autism Identification Team.
This child was evaluated on _____ (date) for an autism spectrum disorder (ASD).

The team ❑ **did /** ❑ **did not** (check one) make an identification of ASD for this child.

The team identified the following co-occurring condition(s):
_____
_____
_____

The child ❑ **is /** ❑ **is not** (check one) eligible for Early Intervention services.

If eligible, s/he qualifies under the following eligibility category:

- ❑ Autism
- ❑ Developmental Delay
- ❑ Intellectual Disability
- ❑ Vision Impairment
- ❑ Hearing Impairment
- ❑ Orthopedic Impairment
- ❑ Deaf-Blind
- ❑ Traumatic Brain Injury

The child ❑ **is /** ❑ **is not** (check one) eligible for Early Childhood Special Education services.

If eligible, s/he qualifies under the following eligibility category:

- ❑ Autism
- ❑ Developmental delay
- ❑ Intellectual Disability
- ❑ Vision impairment
- ❑ Hearing Impairment
- ❑ Communication
- ❑ Orthopedic impairment
- ❑ Specific learning disability
- ❑ Emotional disturbance
- ❑ Deaf-blind
- ❑ Traumatic brain injury
- ❑ Other health impairment

Referrals were made to:

☐ _____for further evaluation
❑ Social Security Income (SSI)
❑ Oregon Developmental Disabilities
❑ CaCoon home-visiting nurse care coordination services (public health)
❑ Autism Society of Oregon or ❑ Autism Speaks
❑ Other: _____
❑ Other: _____

Notes:_____
_____
_____
_____

Autism Identification Team Physician _____ (signature)

Autism Identification Team Physician contact information: _____

For more information or to make a referral to:
The _____ (insert team) Autism Identification Team, Please Call (insert #): ____-____-_____