**BOSTON MEDICAL CENTER NEURODIVERGENT URBAN YOUTH (NUY) EXTERNAL REFERRAL INTAKE FORM** **Fax this completed referral intake form to (617) 638-6756.**

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| **First Name:** | | **Last Name:** | |
| **Date of Birth:** | | **Gender** M ☐ F ☐ Other: | |
| **Primary Language:** | | **Interpreter Required** Yes ☐ No ☐ | |
| **Patient Phone** *(if age 18+):* | | **Patient Email** *(if age 18+)* : | |
| **Legal Guardian** Yes ☐ No ☐ | | **If yes, complete the following guardian information:** | |
| *Name/s:* | *Phone/s:* | *Patient Relation:* | |
| **Health Care Proxy (HCP)** *(if age 18+)* Yes ☐ No ☐ | | **If yes, complete the following HCP information:** | |
| *Name/s:* | *Phone/s:* | *HCP Active* Yes ☐ No ☐ | |
| **Patient Insurance** | Carrier: | ID Number: | |

## PARENT/CAREGIVER/GUARDIAN INFORMATION *(required if under age 18 or has a legal guardian)*

| | |
|---|---|
| **First Name/s:** | **Last Name/s:** |
| **Phone:** | **Email:** |
| **Primary Language:** | **Interpreter Required:** |

## PRIMARY CARE CLINICIAN

| | |
|---|---|
| **First Name:** | **Last Name:** |
| **Office Name:** | **Office Address:** |
| **Primary Phone:** | **Primary Fax:** |

## REFERRAL REASON

| | |
|---|---|
| **Autism spectrum disorder (ASD)** ☐ | **Describe your concern and/or question to answer:** |
| **Attention deficit/hyperactivity disorder (ADHD)** ☐ | |
| **Intellectual disability (ID)** ☐ | |
| **Learning disability (LD)** ☐ | |
| **Other:** | |

## FOR ASD CONCERN - complete all areas of concern:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Social communication, describe:** | | | | | | | |
| **Repetitive behaviors, describe:** | | | | | | | |
| **Aggressive behavior towards others or self, describe:** | | | | | | | |
| **Eye contact:** | None ☐ | | Minimal ☐ | | Normal ☐ | | |
| **Social interactions:** | None ☐ | | Minimal ☐ | | Normal ☐ | | |
| **Sleep patterns:** | High distruption ☐ | | Low distruption ☐ | | Normal ☐ | | |
| **Diet or oral intake:** | Restricted ☐ | | Fair ☐ | | Normal ☐ | | |
| **Hypo/hypersensitivity:** | Light ☐ | | Sound ☐ | | Textures ☐ | | |

## Has the patient previously been evaluated in BMC DBP, neurology and/or psychiatry?

| | | |
|---|---|---|
| No ☐ Yes ☐ | **If yes, complete following:** | *Clinician Name/s:* |

**Has patient previously been evaluated for referral concern by another clinician** *(e.g., psychologist, school, neurologist, etc.)?*

| No ☐ Yes ☐ | **If yes, complete following:** |
|---|---|
| *Date of Evaluation:* | *Clinician Name & Agency:* |
| *Evaluation Type:* | *Evaluation diagnosis:* |

## HEARING & VISION SCREENINGS

| | | | |
|---|---|---|---|
| **Most Recent Vision Screening Date:** | Pass ☐ | Fail ☐ | Referral to: |
| **Most Recent Hearing Screening Date:** | Pass ☐ | Fail ☐ | Referral to: |

## EDUCATION & EMPLOYMENT

| **ATTENDING SCHOOL** | **GRADUATED SCHOOL** |
|---|---|
| Anticipated Graduation Date: | Graduation Year: |
| **Which of the following school services are in place:**<br>IEP ☐ 504 Plan ☐ Transition Planning Form ☐<br>Pre-ETS ☐ Chapter 688 Referral ☐ | **Which of the following school services were received:**<br>IEP ☐ 504 Plan ☐ Transition Planning Form ☐<br>Pre-ETS ☐ Chapter 688 Referral ☐ |
| | **Which of the following describes current day-to-day:**<br>Employment ☐ Day Program ☐<br>Further Education ☐ Other: |

| **ADDITIONAL SERVICES** | **Current** ☐ | ☐ | **Agency** | **Frequency of Service** |
|---|---|---|---|---|
| Applied behavioral analysis (ABA) | | | | |
| Speech and language therapy (SLP) | | | | |
| Occupational therapy (OT) | | | | |
| Physical therapy (PT) | | | | |
| Mental health counseling or therapy | | | | |
| Other | | | | |

## REQUIRED DOCUMENTATION *(submit with NUY referral intake form)*

- **Encounter note that prompted referral**
- **Current hearing and vision results** *(in office screening or consult reports)*
- **Current IEP (including Transtion Planning Form) or 504 Accommodation Plan** *(most recent if graduated school)*
- **Results of validated ADHD screening tool e.g., V*anderbilt*** *(applicable for ADHD concern)*
- **Original diagnostic report** *(if seeking follow-up care)*

**FAX COMPLETED INTAKE FORM TO: (617) 638-6756**

Fax additional required documentation (not already faxed with intake form) to (617) 414-3661.

Clinical concerns to discuss, call Dr. Augustyn: (617) 414-7418.

**Thank you for collaborating with us to support your patients while they wait to be evaluated in the NUY Clinic.**