

**Request for Information**

**Patient Demographic Information**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Parent/Guardian Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Insurance Information**

Primary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Information**

Client’s Diagnosis Code (e.g. Autistic Disorder): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Diagnosis (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Diagnostic Severity (per DSM-5 Diagnostic Criteria):

\_\_\_Level 1: Requiring Support

\_\_\_Level 2: Requiring Substantial Support

\_\_\_Level 3: Requiring Very Substantial Support

**Services Interested In** (\*Check all that apply)

❏ ABA Services

❏ IBHS Services

❏ Parent and Family Trainings

❏ Parent and Family Support Groups

❏ Behavior Presentations

❏ School Consultation