

<DATE>

Dear Provider,

Thank you for your interest in an Autism Diagnostic Observation Schedule (ADOS) evaluation. Please use this form to serve as your order and referral for services. Please mark all observations/concerns that apply and remember your documentation must correlate with your office notes. Examples are not exhaustive, feel free to add specifics if relevant.

Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persistent deficits in social communication and interaction (all need to be checked and documented in office notes)

[ ]  Deficits in social emotional reciprocity (Failure of normal back- and-forth conversation, reduced sharing of interests, emotions, or affect, failure to initiate or respond to social interactions)

[ ]  Deficits in nonverbal communication used in social interactions (Poorly integrated verbal and nonverbal communication, abnormalities in eye contact or body language, lack of facial expressions, and nonverbal communication)

[ ]  Deficits in developing, maintaining, or understanding relationships (difficulties adjusting behavior to social context, to difficulties with sharing imaginative play, making friends, or absence in interest of peers)

Restricted, repetitive patterns or behavior or interests (at least 2 need to be checked and documented in office notes)

[ ]  Repetitive motor movements (i.e. lining up toys, echolalia)

[ ]  Insistence of sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (eating same foods, extreme distress with small changes)

[ ]  Highly restricted fixated interest with abnormal intensity and focus

[ ]  Hyper or hypo reactivity to sensory input or unusual interest in sensory aspects of the environment (pain, temperature, sounds, textures)

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Other Criteria

[ ]  Symptoms must be present in early development.

[ ]  Symptoms must cause clinically significant impairment in social, occupational or any other important area of function.

[ ]  These disturbances are not better explained by an intellectual disability, or global developmental delay. (social communication should be below that expected for general developmental level)

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By providing a license number, you are attesting that the above diagnosis is confirmed through a comprehensive assessment.

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fax to (810) 648-5107 or mail/email this order form and demographic sheet.