



Dear Parents,

Thank you for referring your child to the Center for Autism and Related Disabilities (CARD). CARD is a state funded agency whose purpose is to serve individuals with Autism Spectrum Disorder (ASD) or Related Disabilities, their families, schools, and community. Please review the materials in your packet as they provide more information on ASD, Related Disabilities, and CARD services. The referral process is as follows:

1. Complete the enclosed forms.
2. Complete the permission to observe and/or exchange information form including all agencies or individuals with whom we can exchange information about your child. Include your signature and the date.
3. To comply with the legislative rule under which we function, documentation of a diagnosis of ASD or Related Disabilities must be submitted for individuals 6 years of age or older. Examples of appropriate documentation include: diagnostic evaluation reports, school evaluations or IEP indicating exceptionality of Autism/ASD.
4. FSU-CARD does not require a diagnosis of ASD for children who are under 6 years of age. Eligibility for these children is determined through a screening process that may include use of questionnaires, interviews, and/or direct observation. Children determined eligible through the screening process will be required to obtain a formal diagnosis of ASD by age 6 in order to remain a CARD client.
5. Return all information in the enclosed envelope.
6. Once your referral is received and eligibility is established, a CARD consultant will contact you to discuss our services as they relate to you and your need.

FSU CARD has offices in Tallahassee, Panama City and Pensacola. For more information, please call the office closest to you. Contact information is listed below:

Tallahassee (850) 644-4367 or (800) 769-7926

Panama City (850) 215-4330 or (866) 863-0138

Pensacola (866) 863-0138

We look forward to meeting you and your child.

A handwritten signature in black ink that reads "Catherine Zenko".

Catherine Zenko, M.S., CCC-SLP
Director, FSU CARD



FSU Center for Autism and Related Disabilities
Child Referral/Intake



All of CARD services are FREE of charge.

Please fill out this referral packet as completely as possible, print, sign, and return via email, fax, or mail to CARD. You will be contacted by CARD staff when your referral packet has been received in our office.

Please type directly into this form, or print and complete in ink.

Date: _____

Name: _____ Date of Birth: _____

Gender: Male Female Transgender Do not identify as male, female, or transgender

Race: American Indian/Alaskan Native Asian Native Hawaiian or Other Pacific Islander

Black or African American White More than one race I prefer not to answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino I prefer not to answer

Parent(s)/Guardian: _____

E-Mail: _____

Mailing Address: _____

City, State, Zip: _____

County: Phone: (H) (W) (C)

May we leave a voice message? If so, which number(s):

Parent (if different): _____

E-Mail: _____

Mailing Address (if different): _____

City, State, Zip: _____

County: Phone: (H): (W): Cell:

May we leave a voice message? If so, which number(s)?

Diagnosis: _____

By Whom: _____ Date: _____

A COPY OF AN EVALUATION REPORT DOCUMENTING DIAGNOSIS IS REQUIRED



FSU Center for Autism and Related Disabilities
Child Referral/Intake



Other Health Concerns: _____

Medications: _____

School Name: _____ Teacher/School Contact: _____

Type of Class: _____ Grade: _____

School Therapy Services: _____

Other Therapy Services/Agencies: _____

What are your primary concerns? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Communication | <input type="checkbox"/> Seeking a diagnosis |
| <input type="checkbox"/> Challenging behavior(s) | <input type="checkbox"/> Social skills/Interaction |
| <input type="checkbox"/> Education/School/Academic related | <input type="checkbox"/> Understanding autism spectrum disorder |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Housing | _____ |
| <input type="checkbox"/> Potty training | |

Where can we assist you? Check all that apply.

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Home | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> School | _____ |
| <input type="checkbox"/> Community | |
| <input type="checkbox"/> Work | |

FSU Center for Autism and Related Disabilities
 2312 Killearn Center Blvd., Bldg. A, Tallahassee, Florida 32309

(800) 769-7926/850-644-4367
(850) 644-3644 – Facsimile

FSU Panama City Center for Autism and Related Disabilities
 2611- A West 23rd Street, Panama City, Florida 32405

(866) 863-0138/ (850) 215-4330
(850) 215-4337 – Facsimile

FSU Pensacola Center for Autism and Related Disabilities
 5154 Bayou Blvd., Pensacola, Florida 32503

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**FSU Center for Autism and Related Disabilities
Child Referral/Intake Continued**



What is your Annual Household Income? (Optional) _____

Does your family receive help from any of the following programs or services? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Agency for Persons with Disabilities (APD) | <input type="checkbox"/> Phone or Fuel Assistance |
| <input type="checkbox"/> Child Care Assistance | <input type="checkbox"/> TANF (Temporary Assistance for Needy Families) |
| <input type="checkbox"/> Disability Benefits like SSI (Supplementary Security Income) | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Early Intervention for your Infant or Toddler | <input type="checkbox"/> Visiting Nurse or other Home Visiting like Healthy Families |
| <input type="checkbox"/> Food stamps (SNAP) | <input type="checkbox"/> WIC (Women, Infants, & Children Nutrition Program) |
| <input type="checkbox"/> Group Home/Intermediate Care Facility (ICF)/Institutional Care | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Head Start or Early Head Start | _____ |
| <input type="checkbox"/> Housing Assistance | _____ |
| <input type="checkbox"/> Medicaid | |

Were you referred to CARD? If so, by whom?

Name/Title: _____

Agency: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

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FSU Center for Autism & Related Disabilities

Mental Health Screening



1. Has your child intentionally hurt himself/herself or others? Please describe.

2. Has your child ever talked about hurting himself/herself or others?

3. Does your child have a mental health diagnosis other than Autism? Please describe.

4. Has your child received psychiatric treatment or been hospitalized due to mental health issues? When? Please describe.

5. Is your child currently receiving counseling? Where?

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FSU Center for Autism & Related Disabilities
Permission to Observe & Exchange Information



I hereby authorize & request the Florida State University Center for Autism and Related Disabilities permission to observe CARD client, _____

I hereby authorize & request the Florida State University Center for Autism and Related Disabilities permission to exchange information about the CARD client listed above with the school, agencies, and individuals listed below. I also grant the agencies listed below permission to exchange information and release educational, medical, psychological, psychiatric, or other records to the Florida State University Center for Autism and Related Disabilities.

Please list below individuals and agencies with whom CARD may exchange information:

School(s)/County School Systems:

Two horizontal lines for listing school or county school systems.

Doctor(s):

Two horizontal lines for listing doctor(s).

Other agencies/therapists/specialists:

Two horizontal lines for listing other agencies, therapists, or specialists.

Other family members:

Two horizontal lines for listing other family members.

Was your child ever a client of the FIRST Words Project? YES NO
Do you give consent to share information? YES NO

(Signature of Legal Guardian or Adult Client if 18 or older) (Date)
I understand that I may revoke this authorization at any time.

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