Center for Autism and Related Disabilities (CARD)
Providing Support and Assistance to Optimize Potential

Hello,

Thank you for your referral 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. The referral process is as follows:

1. Complete the enclosed forms.

2. As the legal guardian of a person 18 years of age or older, we require your signature on the **Permission to Observe and/or Exchange Information Form** in order to exchange information with you or others. A copy of your guardianship documentation must be included with the referral.

3. Documentation of a diagnosis of Autism Spectrum Disorder (ASD) or Related Disabilities must be submitted. Examples of appropriate documentation include: diagnostic evaluation reports from a neurologist, physician, psychiatrist, psychologist, or social worker. Documentation may also include school evaluations or Individualized Education Plans (IEPs) indicating Autism/ASD as the educational exceptionality.

4. The intake forms can be returned via
   - **Email: autism@med.fsu.edu**
   - **Fax: (850) 215-4337**
   - **Mail: 4900 Bayou Blvd., Suite 200, Pensacola, FL 32503-Attention: Intake Coordinator**

   Once received, our Intake Coordinator will contact you via email or phone.

FSU CARD has offices in Tallahassee, Panama City and Pensacola. For more information call the office closest to you.

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.

Catherine Zenko

Catherine Zenko, M.S., CCC-SLP

Director, FSU CARD

FSU Center for Autism and Related Disabilities

Referral/Intake (Adult)

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

Mailing Address: _____

City, State, Zip: _____

County: _____ Email: _____

Phone: (H) _____ (W) _____ (C) _____

Parent(s)/Guardian: _____

***** PLEASE INCLUDE GUARDIANSHIP DOCUMENTATION *****

Mailing Address (if different): _____

City, State, Zip: _____

County: _____ Email: _____

Phone: (H) _____ (W) _____ (C) _____

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

Diagnosis: _____

By Whom: _____ Date: _____

*****PLEASE SEND COPY OF EVALUATION REPORT DOCUMENTING DIAGNOSIS*****

FSU Center for Autism and Related Disabilities

Referral/Intake (Adult) (continued)

Other Health Concerns: _____

Medications: _____ Insurance:_____

Name of School (if applicable): _____

Place of Employment (if applicable): _____

Contact Name:_____Phone: _____

Mailing Address: _____

City, State Zip: _____

Other Agencies/Service Providers: _____

_____

What are your primary concerns? Check all that apply.

- ☐ Communication
- ☐ Challenging behavior(s)
- ☐ Education/School/Academic
- ☐ Related Employment
- ☐ Housing
- ☐ Potty training
- ☐ Seeking a diagnosis
- ☐ Social Skills/Interaction
- ☐ Understanding autism spectrum disorder
- ☐ Other: _____

Where can we assist you? Check all that apply:

- ☐ Home
- ☐ School
- ☐ Community Work
- ☐ Other: _____

What is your Annual Household Income? (Optional)_____

_____

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
4900 Bayou Blvd., Suite 200, Pensacola, Florida 32503
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FSU Center for Autism and Related Disabilities

Crisis Screening

1. Is the referred individual in danger of injuring him or herself or others?

_____

2. Has the referred individual injured him or herself or others? In what manner? Is he or she likely to continue?

_____

_____

3. Has property been damaged or destroyed and is it likely to continue?

_____

_____

4. Has or will this person's behavior interfere with their ability to remain and participate in their classroom/home/community?

_____

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

Name/Title: _____

Agency: _____

Mailing Address: _____

City, State: _____ Zip: _____

Phone: _____

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Profile

1. How does the referred individual communicate? (Check all that apply):
   - ☐ Vocalizations
   - ☐ Sign Language/Gestures
   - ☐ Single Words
   - ☐ Pictures
   - ☐ Two or three word phrases
   - ☐ Communication Device
   - ☐ Sentences
   - ☐ Other: _____

2. How does he or she know you:

   Wants/Needs? _____

   When he or she needs help? _____

   When he or she doesn't like something? _____

3. How do you provide information to him or her? (Check all that apply)
   - ☐ Objects
   - ☐ Pictures
   - ☐ Gestures
   - ☐ Verbal
   - ☐ Visual Schedules
   - ☐ Social Stories
   - ☐ Other:

4. List some things he/she does well:

   _____

   _____

5. List some things that help him/her stay calm:

   _____

6. What are some of his/her favorite things, toys, or characters? What are his/her interests.

   _____

7. List things or events that he/she doesn't like or finds difficult:

   _____

8. What are your concerns about him/her at this time?

   _____

   _____

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Mental Health Screening

1. Has this individual intentionally hurt himself/herself or others? Please describe.

   _____
   _____

   _____

2. Has this individual ever talked about hurting himself/herself or others?

   _____

   _____

   _____

3. Does this individual have a mental health diagnosis other than Autism? Please describe.

   _____

   _____

   _____

4. Has this individual received psychiatrist treatment or been hospitalized due to mental health issues? When? Please describe.

   _____

   _____

   _____

5. Is this individual currently receiving counseling? Where?

   _____

   _____

6. Has this individual been charged or convicted of a sexual or violent offense? Please describe.

   _____

   _____

   _____

   _____

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FSU Center for Autism and Related Disabilities

Permission to Observe and Exchange Information

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

I hereby authorize and 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)/Community Agencies/Work Site:

_____ _____

_____ _____

Doctor(s):

_____ _____

_____ _____

Other agencies/therapists/specialists:

_____ _____

_____ _____

Other family members:

_____ _____

_____ _____

_____ _____

(Signature of Legal Guardian/Adult Client, if 18 or older) (Date)

I understand that I may revoke this authorization at any time.

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