Anderson Consulting Services
Referral Packet

The Anderson Center Consulting Services Referral Packet includes the following:

- ☐ Consulting Services Referral *
- ☐ Consent for Services*
- ☐ Authorization for Release of Information (optional)
- ☐ Consent for Use of Photographs, Video, Data, and Individuals Name (optional)
- ☐ Documentation of Diagnosis of Developmental Disability*
  - ☐ Psychological Evaluation
  - ☐ Social History
  - ☐ Individualized Education Plan (IEP)
  - ☐ Life Plan (Individualized Service Plan (ISP))
  - ☐ Behavior Intervention Plan & Supporting Data
  - ☐ Functional Behavioral Assessment (FBA)
- ☐ Completed Transmittal for Determination of Developmental Disability **
- ☐ Family Availability
- ☐ OPWDD eligibility**

* Form must be returned prior to services
**Required only for referrals for Family Support Services

Please return this form and all documentation to:

Lisa Susczynski
Consultation Administrator
Anderson Center for Autism
4885 Route 9, P.O. Box 367
Staatsburg, NY 12580-0367 (845) 889-9496 (Fax)
AndersonConsulting@andersoncares.org (Email)

Please contact our Consultation Administrator at 845-889-9616 if you have any questions.

Consultation Services Referral

Please complete this form and return with available documentation

Name of Service Recipient: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

TABS ID Number: _____ Medicaid Number: _____

Referral Source Information:

Please indicate how you were referred to our services:

☐ MSC ☐ Print Ads ☐ Internet ☐ Radio ☐ Conference/Event ☐ School District

☐ Agency Reputation ☐ Parent ☐ Other: _____

Referral Source: _____ Date of Referral: _____

Service/s Requested:

Please check the service/s you are requesting.

☐ **Family Support Services** ☐ **HCBS Waiver Service/Family Education and Training**

☐ **Private Pay Services**

Service Requested: _____

Parent/Guardian Contact Information:

Parent/Guardian Name: _____ Relationship to Individual: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Parent/Guardian Name: _____ Relationship to Individual: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contact Information:

Name: _____ Phone Number: _____

Relationship to Individual: _____

School District Contact Information:

If service is to be conducted in school, please include the following:

School District: _____ School: _____

Grade Level: _____ Classroom: _____ (ex. Inclusion, Self Contained)

Teacher's Name: _____

Email: _____ Phone: _____

CSE Name: _____

Email: _____ Phone: _____

IEP Mandate (if applicable): _____

Medicaid Service Coordinator (MSC) Information:

If individual has a Medicaid Service Coordinator (MSC), please include the following:

MSC Name: _____ Agency: _____

Email: _____ Phone: _____

Other Services:

Please indicate all other services being received through Office for Persons with Developmental Disabilities (OPWDD) and/or Taconic Developmental Disabilities Regional Office (Taconic DDRO) [if applicable]:

- ☐ Camp
- ☐ Crisis Intervention
- ☐ Environmental Modifications/Adaptive Equipment
- ☐ Family Care
- ☐ In-Home Services
- ☐ Recreation
- ☐ Residential Services
- ☐ Transportation
- ☐ Counseling
- ☐ Day Services/Day Habilitation
- ☐ Employment Services
- ☐ Health Care
- ☐ Parent Advocacy and Training
- ☐ Respite
- ☐ Service Coordination
- ☐ Waiver Services

Medical History Information:

What is your child's medical diagnosis? _____

Are your child's immunizations current? If not, why? _____

_____

Medications:

Please list all medications currently being taken by the individual.

_____

_____

Please provide all pertinent medical information.

Condition	Yes	No	Description	Last Occurrence
Allergies (Include all: season, food, medication, pet, etc.)				
Asthma				
Seizure Disorder				
Epilepsy				
Diabetes				
Cardiac Issues/ Heart Disease				
Respiratory Issues				

Does your child	Yes	No	Describe
Experience any physical challenges?			(i.e.: motor skills deficits, use of helmet/brace)
Wear glasses?			
Wear a hearing aid device?			

Has your child had hospitalizations related to behaviors?_____

Please list any related services (Physical Therapy, Occupational Therapy, etc.) the individual participates in?

Communication Skills: How does the individual make their wants and needs known?

	Yes	No	Describe
Example: Gestures	***X***		***When asked he will reach for the activity he wants to use.***
Speech/Verbal Language			
Gestures			
Picture Systems (PECS)			
Communication Device			
Directing person to what is wanted			
Aggression			

Adaptive Daily Living Skills: What is the level of independence the individual has with Daily Living Skills?

ADL skill	Independent	Needs Prompting	Needs Assistance	Full Support	Describe as needed
Example: Toileting		***X***			***Needs to be verbally reminded to wipe***
Toileting					
Showering					
Tooth brushing					
Dressing					
Maintaining bedroom/ belongings					
Laundry					
Household Chores					
Other life skills					

Please describe how the individual responds when feeling:

Emotion/Feeling	Describe
Example: Happy	***Smiles, jumps up and down, laughs***
Happy	
Sad	
Angry	
Tired	
Excited	
Hungry	
Scared	

Other Concerns:

Does the individual have any extreme fears or phobias (i.e. open places, malls, closed places, dark places, the movies, etc.)?

_____

What hobbies or interests does he/she have?

	When	Where	Describe
Example: drawing	***Anytime***	***On the floor***	***He likes to draw on purple paper with crayons. He likes to draw animals.***

Social Skills:

	Yes	No	Describe
Does your child tolerate group activities?			What Kind?
Are there favored activities?			What are the activities?
Does your child enjoy individual activities?			What kind?
Does your child have favorite toys/items?			What are they?
Can your child tolerate haircuts?			

What is your child's preferred reinforcers? _____

_____

Behavioral Challenges: What are your child's current challenging behaviors?

Challenging Behavior	Yes	No	Describe
Aggressive Behavior			
Hitting			
Kicking			
Spitting			
Pinching			
Hair pulling			
Scratching			
Biting			

Self-injurious Behavior			
Hitting self			
Biting self			
Hitting head on objects			
Scratching self			
Hair pulling			
Flopping or Dropping			
Elopement			

Transition	**Yes**	**No**	**Describe**
Difficulty from 1 activity to the next			
Difficulty from 1 location to another			
Refusing to get on/off bus			
Screaming			
Wiping items off table			
Urination or Bowel movements other than toilet			
Smearing feces			
Property Destruction			
Repetitive Behavior			
Mouthing inedible objects			
Swallowing inedible objects			
Other			
Other			

History of Challenging Behaviors:

Behavioral Supports Tried	**Yes**	**No**	**Responses – please describe**
Redirection			
Token Economy/System			
Verbal Praise			
Physical Supports			
Environmental Change			
Has your child had a serious injury related to their behaviors?			
Has your child caused serious injury to others?			
Does your child use protective equipment			(i.e., helmet, harness, arm guards)

Anderson Center for Autism
LIFELONG LEARNING℠
Consulting Services

Consent for Services

This consent is required **prior to scheduling of a service** for your child and/or family. These services may require: observations, formal testing, parent/guardian or teacher consultations, review of your child's records, videotaping and/or audiotaping. We will inform you prior to administering any evaluation. **Please complete, sign, and date this form.**

I _____, parent/guardian of _____

_____ give Anderson Center Consulting permission to provide services to my child.

_____ ***I give consent for the consultant providing my services to bring other consultants, as necessary for observations, assistance, and/or training.***
(Please initial to indicate consent is being given)

Please note that the Consent for Services Form is valid for one year from date of signature, unless otherwise specified in writing.

_____ _____
Parent/Guardian Signature Date

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Family Availability Form

As our program is designed to provide support/training to parents and caregivers; your child does not need to be present during each visit. However, please note there may be times the provider requests your child's presence and this will be scheduled collaboratively.

To allow us to better serve you, please complete the availability chart below by indicating the hours you would be available for services for each day listed. Please note that this does not guarantee scheduling days and times.

Monday	Tuesday	Wednesday	Thursday	Friday

Individual's Name _____ Date _____

4885 Route 9 P.O. Box 367 Staatsburg, NY 12580 Tel: 845-889-9616 Fax: 845-889-9496 www.AndersonCenterforAutism.org