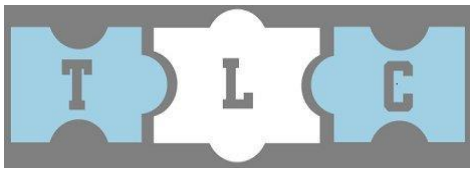
**Treatment & Learning Center for Children with Autism**
**and**
**Autism Outreach Services**




**OFFICE: 903-593-4004 FAX: 903-593-4121**

DATE: _____

Child's Name: _____ DOB: _____

Parent/Guardian: _____ Relationship: _____

Child lives with: ____Mother & Father ____Mother _____Father

____Other/Legal Guardian (please specify): _____
***guardianship papers must accompany application

Primary language spoken in the home: _____

Address: _____ City: _____

Phone Number (home): _____ (work): _____

Referring Person/Title: _____ Referring Agency _____

Phone Number: _____

School youth attends:_____
Grade:_____
Diagnosis: _____
AC DMR or endorsement date:_____
Attachments: (please check and attach the following forms)
____Medical History
____Diagnosis of mental retardation or autism assessment (DMR)
____Psychological testing or assessment
____Individual Education Plan (IEP)
____Full Individual Evaluation (FIE)
____Any additional relevant forms or information

Date of Parent/Guardian consent for referral to Andrews Center:
Obtained from: _____parent _____guardian
Date obtained: _____
Describe current behaviors/Reason for referral;
_____
_____

_____ _____
Parent/Guardian Representative of Referring school or agency