RUTGERS
Center for Adult Autism Services

Rutgers Center for Adult Autism Services

Intensive Outpatient Clinic Referral Form

Section I: Patient Information

First Name	Last Name	Date of Birth

Gender ☐ Male ☐ Female ☐ Nonbinary	Height (ft./in.)	Weight (lbs.)

Street Address	City, State	Zip	Is this: ☐ a personal home ☐ a residential/ group home

If you selected that the above address is a residential/group home, complete the following:

Company Name	Contact Person Name	Contact Person Title

Phone Number	Email Address

Street Address	City, State	Zip

Legal Guardian First Name	Legal Guardian Last Name	Relation to Patient (e.g., parent, sibling, court appointed)

Street Address	City, State	Zip

Phone Number	Email Address

Preferred Form of Contact ☐ Phone ☐ Email ☐ Other:_____	Best Time to Reach ☐ Morning ☐ Afternoon ☐ Other:_____

Has this individual been seen by the Rutgers Center for Adult Autism Services (RCAAS) before?
☐ Yes ☐ No

The following section is only applicable to NJ Residents

Support Coordinator Name	SC Agency	Patient's Current Tier (indicate acuity if applicable)	Program Enrollment ☐ SP ☐ CCP
Phone Number	Email Address		
Street Address	City, State	Zip	

Primary Care Physician Name (First and Last)	Date of Last Visit
Office Phone Number	Email Address
Street Address	City, State	Zip

Person Completing this Form	Relationship to Patient	Date Completing this Form

Who Referred You to Our Program?

Name (First and Last)	Affiliation
Phone Number	Email Address
Street Address	City, State	Zip

Emergency Contact (First and Last)	Relationship to Patient
Phone Number	Email Address

Section II: Social History

If the patient currently lives in a personal home, complete the following

Name of Primary Caregiver	This is the patient's ☐ Biological Parent ☐ Adoptive Parent ☐ Biological Sibling ☐ Adoptive Sibling ☐ Other _____
How long has the patient lived in this home?	Has the patient ever received residential services before? (this does not include hospitalizations) ☐ Yes ☐ No If yes, where?

Please provide a list of individuals who currently live with the patient

Name	Age	Relationship to Patient

If the patient currently lives in a group home, complete the following

Company Name	How long has the patient lived here?	Is the patient staffed at a ratio of 1:1 or higher? ☐ Yes ☐ No
How many other residents live with the patient?	What is the average age of the other residents?	This home is ☐ Males Only ☐ Females Only ☐ Mixed Gender

Has the patient lived in any other residential placements previously? (this does not include hospitalizations) • Yes • No If yes, please list below

Facility Name	Dates of Residence	Was the patient staffed at a ratio of 1:1 or higher?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Biological/Adoptive Mother's Name	Biological/Adoptive Mother 's Age (if deceased, check here ☐)
Biological/Adoptive Mother's Occupation	Is the patient's biological/adoptive mother currently active in the patient's care/life? ☐ Yes ☐ No
Biological/Adoptive Father's Name	Biological/Adoptive Father's Age (if deceased, check here ☐)
Biological/Adoptive Father's Occupation	Is the patient's biological/adoptive father currently active in the patient's care/life? ☐ Yes ☐ No
The patient's parents are ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married	

Check any of the following situations the patient is currently experiencing or has previously experienced

☐ CPS/Foster Placement ☐ Tobacco Use ☐ Alcohol Abuse ☐ Drug Abuse

☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Caregiver Negligence

☐ Legal Problems/Arrest ☐ Other_____

If any of the above were checked, please provide additional detail

Please specify how the patient communicates

☐ Spoken English ☐ Spoken Non-English Language (specify _____)

☐ American Sign Language (ASL) ☐ Picture Communication System ☐ Augmentative Communication System (e.g., iPad, Dynavox) ☐ Other: _____

Please specify the communication level

☐ Social Conversational ☐ Answers Questions/ Engages in to-and-fro conversation

☐ Short Sentences ☐ 2-3 Word Phrases ☐ Single Words ☐ Leading Others Towards Desired Items ☐ Pointing ☐ Other: _____

Section III: Medical History and Intervention

Has the patient ever required a surgical procedure? ☐ Yes ☐ No
If yes, please describe below

Surgery	Date (or age)	Reason

Has the patient experienced a severe head or bodily injury? ☐ Yes ☐ No
If yes, please describe below

Please describe the patient's sleeping habits

☐ No concern ☐ Regular sleep/wake times ☐ Irregular sleep/wake times ☐ Doesn't stay asleep

☐ Nocturnal Enuresis (nighttime bed wetting) ☐ Nocturnal Encopresis (nighttime bed soiling)

☐ Other:

Please describe the patient's appetite and eating habits

☐ No concern ☐ Food selectivity ☐ Swallowing deficit ☐ Vomiting ☐ Packing

☐ Obesity ☐ Rumination (bringing back up and/or rechewing partially digested food that has already been swallowed) ☐ Aerophagia (excessive air swallowing)

☐ Other:

Describe the patient's toileting habits

☐ No concern (independently uses toilet) ☐ Requires minor assistance in the bathroom, but otherwise, is independent ☐ Requires pullups/diapers ☐ Nighttime accidents

☐ Other:

Does the patient have any seasonal, food, of medication allergy? ☐ Yes ☐ No
If yes, please list allergies below

Does the patient require any special equipment?

☐ No equipment needed ☐ Crutches ☐ Cane ☐ Wheelchair ☐ Walker ☐ Gait belt

☐ Leg Braces ☐ Arm/Hand Splints ☐ Hearing aid ☐ Nebulizer ☐ Oxygen

☐ Glasses ☐ Feeding Tube ☐ Other:

Please complete the following section regarding psychiatric diagnoses that have been provided by a qualified professional.

Is the patient diagnosed with Intellectual Disability? ☐ Yes ☐ No If yes, please select the severity level ☐ Unsure/Unspecified ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
Is the patient diagnosed with Autism Spectrum Disorder? ☐ Yes ☐ No
Is the patient diagnosed with an Anxiety Disorder? ☐ Yes ☐ No If yes, please describe
Is the patient diagnosed with a Mood Disorder? ☐ Yes ☐ No If yes, is the disorder Bipolar I or II Disorder? ☐ Yes ☐ No If the disorder is not Bipolar or II Disorder, please describe the disorder
Is the patient diagnosed with a Depressive Disorder? ☐ Yes ☐ No
Is the patient diagnosed with Obsessive Compulsive Disorder (OCD)? ☐ Yes ☐ No
Is the patient diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)? ☐ Yes ☐ No
Is the patient diagnosed with Post-traumatic Stress Disorder (PTSD)? ☐ Yes ☐ No
Is the patient diagnosed with Disruptive Behavior Disorder/Conduct Disorder? ☐ Yes ☐ No
Is the patient diagnosed with Intermittent Explosive Disorder? ☐ Yes ☐ No
Is the patient diagnosed with Pica? ☐ Yes ☐ No
Please list any other psychiatric diagnoses the patient has received below

Please list any medical diagnoses that have been provided by a qualified professional below

Is the patient currently taking any medication? ☐ Yes ☐ No
If yes, complete the following

Medication	Dosage & Administrations Per Day	Prescribing Physician	Reason for Medication	Date Started

Are there any psychiatric medications the patient was previously prescribed? ☐ Yes ☐ No
If yes, complete the following

Medication	Dosage & Administrations Per Day	Reason for Medication	Start Date (or Year)	End Date (or Year)

Please complete the following for any specialty services the patient receives			
Specialty	Physician Information	Purpose	Duration of Services
Primary Care Physician (PCP)	Name: Address: Phone Number:		Patient Since _____
Psychiatrist	Name: Address: Phone Number:		Patient Since _____
Speech Therapist	Name: Address: Phone Number:		Patient Since _____
Occupational Therapist	Name: Address: Phone Number:		Patient Since _____
Physical Therapist	Name: Address: Phone Number:		Patient Since _____
ABA Therapist	Name: Address: Phone Number:		Patient Since _____
Other _____	Name: Address: Phone Number:		Patient Since _____

Section IV: Family History

Please check any of the following conditions that are or have been present in the patient's immediate or extended biological family					
	Sibling	Mother	Father	Mother's Relatives	Father's Relatives
Developmental Delay					
ADHD					
Intellectual Disability					
Learning Disability					
Cerebral Palsy					
Blindness					
Deafness					
Seizures					
Autism					
Tics/Tourette's					
Depression					
Anxiety					
Suicide					
OCD					
Schizophrenia					
Sleep Disorder					
Alcohol Abuse					
Drug Abuse					
Migraine Headaches					
High Blood Pressure					
Diabetes					
Obesity					
Cancer					
Dementia/Alzheimer's					
Genetic Disorder					

Section V: Educational & Employment History

What type of school placement did the patient receive immediately prior to entering adulthood (age of 21)?

☐ No school placement ☐ Home School ☐ Public School ☐ Private School

Please list the schools attended below starting with the most recent school.

Name of School Placement	Location	Years attended

While in school, which special services, if any, did the patient require?

☐ No services ☐ Mainstreamed class ☐ Individualized Education Plan (IEP)

☐ Behavior Intervention Plan (BIP) ☐ Specialized Classroom for Problem Behavior

☐ Staffing ratio of 1:1 or greater ☐ Vision ☐ Speech/Language ☐ Occupational Therapy

☐ Other:

Did the patient attend any higher education institution after high school? ☐ Yes ☐ No

If yes, please indicate the name and location of the institution(s):

Is the patient currently, or has ever been, employed? ☐ Yes ☐ No
If yes, please list all places of employment starting with the most recent job held.

Employer	Location	Job Title	Dates of Employment

Does the patient currently attend a day habilitation program? ☐ Yes ☐ No If yes, complete the following:		
Day Habilitation Company Name	Contact Person Name	Contact Person Title
Phone Number	Email Address	
Street Address	City, State	Zip

Does the patient currently receive prevocational or vocational training outside of the context of a day habilitation program? ☐ Yes ☐ No If yes, complete the following:		
Company Name	Contact Person Name	Contact Person Title
Phone Number	Email Address	
Street Address	City, State	Zip

Does the patient currently receive other day services not previously mentioned? ☐ Yes ☐ No If yes, complete the following:		
What is the service provided?		
Service Provider Name	Contact Person Name	Contact Person Title
Phone Number	Email Address	
Street Address	City, State	Zip

Section VI: Behavioral Concerns and Intervention

Does the patient engage in **self-injurious behavior (SIB)**? ☐ Yes ☐ No
If no, skip to the next box (regarding pica).

If yes, please indicate which of the following the patient engages in.

☐ Head-banging	☐ Hand-to-head hitting	☐ Wrist to surface
☐ Pulling own hair	☐ Biting self	☐ Skin picking
☐ Eye poking	☐ Body hitting	☐ Self-scratching
☐ Self-pinching	☐ Rectal digging	☐ Nose picking
☐ Chin pressing on object	☐ Ear pulling	☐ Self-kicking
☐ Mouth biting	☐ Object to head	☐ Object to body
☐ Body slamming on wall	☐ Joint popping	☐ Teeth grinding
☐ Coprophagia (ingesting feces)	☐ Other:	☐ Other:

Does the patient wear any protective equipment due to their self-injury? ☐ Yes ☐ No
If yes, please indicate the relevant equipment worn by the patient.

☐ Helmet	☐ Arm splints	☐ Knee pads
☐ Gloves	☐ Other:	☐ Other:

How often does the patient engage in self-injurious behavior?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the self-injurious behavior by selecting one of the following

☐ Self-injurious behavior does not result in visible marks on the body and does not consist of any blows close to or contacting the eyes

☐ Self-injurious behavior occasionally results in reddening of the skin and/or mild swelling

☐ Self-injurious behavior frequently results in light scratches, small or shallow breaks in the skin and/or moderate to severe swelling AND/OR self-injurious behavior that occasionally leaves a scar

☐ Self-injurious behavior frequently results in scratches or other breaks to the skin that leaves scars AND/OR SIB either frequently or occasionally involves blows close to or contacting the eyes or results in trauma involving broken bones or lasting tissue damage or disfigurement

Does the patient engage in **pica** (attempting to or successfully eating inedible objects)?
☐ Yes ☐ No
If no, skip to the next box (regarding aggression).

If yes, please describe items that are typically targeted for consumption or have been targeted in the past:

How often does the patient engage in pica?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of pica by selecting one of the following

- ☐ Pica does NOT involve any of the following: solid items larger than ½ inch in diameter (e.g., coins, large buttons), sharp items (e.g., pins, staples), contaminated items (e.g., items from garbage can or ash tray, paint chips), or toxic/poisonous items (e.g., medicines, glue)
- ☐ Pica involves solid items larger than ½ inch in diameter (e.g., coins, large buttons), but not sharp, contaminated, or toxic or poisonous items
- ☐ Pica involves sharp, contaminated, or toxic or poisonous items, but not requiring emergency medical attention (e.g., called physician for advice)
- ☐ Pica involves sharp, contaminated, or toxic or poisonous items requiring emergency medical attention

Does the patient engage in **aggressive behavior**? ☐ Yes ☐ No
If no, skip to the next box (regarding property destruction).

If yes, please indicate which of the following the patient engages in.

☐ Hitting others	☐ Kicking others	☐ Biting others
☐ Punching	☐ Grabbing	☐ Hair pulling
☐ Pinching	☐ Head butting	☐ Slapping
☐ Scratching	☐ Pushing/shoving	☐ Choking
☐ Throwing objects at others	☐ Spitting at others	☐ Chin pressing on others
☐ Body slamming	☐ Pulling on others	☐ Twisting fingers
☐ Limb twisting	☐ Other:	☐ Other:

How often does the patient engage in aggressive behavior?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the aggressive behavior by selecting one of the following

- ☐ Aggressive behavior does not result in any marks to other's bodies and does not involve blows close to or contacting the eyes
- ☐ Aggressive behavior occasionally results in reddening of the skin and/or mild swelling
- ☐ Aggressive behavior frequently results in light scratches, small or shallow breaks in the skin and/or moderate to severe swelling AND/OR aggressive behavior that occasionally results in scars
- ☐ Aggressive behavior fluently results in scratches or other breaks to the skin that leave scars AND/OR aggressive behavior either frequently or occasionally involves blows close to or contacting the eyes or results in trauma involving broken bones or lasting tissue damage or disfigurement

Does the patient engage in **property destruction**? ☐ Yes ☐ No
If no, skip to the next box (regarding disruptive behavior).

If yes, please indicate which of the following the patient engages in.

☐ Throwing objects	☐ Tearing objects	☐ Kicking objects
☐ Swiping objects	☐ Breaking objects	☐ Knocking over furniture
☐ Other:	☐ Other:	☐ Other:

How often does the patient engage in property destruction?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the property destruction by selecting one of the following

☐ Property destruction results in disruption of the property but no permanent damage to paper items, plastic items, electronics, furniture, vehicles, or buildings

☐ Property destruction occasionally results in damage to paper items or other light objects

☐ Property destruction frequently results in breaking pencils, plastic items, electronics, or other breakable items and/or scratches or permanent marks on furniture, walls, cars, etc., AND/OR occasionally results in structural damage

☐ Property destruction frequently results in structural damage to furniture, cars, walls, etc.

Does the patient engage in **disruptive behavior**? ☐ Yes ☐ No
If no, skip to the next box (regarding non-compliance).

If yes, please indicate which of the following the patient engages in.

☐ Banging on objects	☐ Screaming	☐ Stomping feet
☐ Playing with saliva	☐ Spitting on objects	☐ Fecal smearing
☐ Other:	☐ Other:	☐ Other:

How often does the patient engage in disruptive behavior?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the disruptive behavior by selecting one of the following

☐ Disruptive behavior does not interfere with daily activities and the patient can participate fully. Disruptive behaviors occur across less than 25% of waking hours. Minor environmental manipulations are required to avoid disruptions and redirection of these behaviors is easy.

☐ Disruptive behaviors interfere with daily activates such that the patient's participation is limited some of the time (i.e., trips are avoided or are not possible due to high levels of behaviors). Disruptive behaviors occur across more than 25-50% of waking hours. Environmental manipulations are required to avoid disruptions and redirection of these behaviors is manageable.

- ☐ Disruptive behaviors interfere with daily activities such that the patient's participation is limited most of the time (i.e., trips are avoided or are not possible due to high levels of behaviors). Disruptive behaviors occur across more than 50-75% of waking hours. Moderate environmental manipulations are required to avoid disruptions and redirection of these behaviors is difficult, but possible.
- ☐ Disruptive behaviors interfere with daily activities such that the patient cannot participate fully (i.e.., trips are avoided or are not possible due to high levels of behaviors). Disruptive behaviors occur across more than 75% of waking hours. Significant environmental manipulations are required to avoid disruptions and redirection of these behaviors is difficult.

Does the patient engage in **non-compliance**? ☐ Yes ☐ No
If no, skip to the next box (regarding elopement).

If yes, please indicate which of the following the patient engages in.

☐ Saying "No"	☐ Whining/crying	☐ Refusal to complete task
☐ Engaging in SIB	☐ Becomes aggressive	☐ Becomes disruptive
☐ Drops to floor	☐ Slides to floor	☐ Refuses to remain seated
☐ Other:	☐ Other:	☐ Other:

How often does the patient engage in non-compliance?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the non-compliance by selecting one of the following

- ☐ When presented with an instruction, non-compliance frequently occurs and consists of refusing to do the task or whining
- ☐ When presented with an instruction, non-compliance frequently occurs and consists of crying, or sliding/dropping to the floor AND/OR non-compliance occasionally occurs and consists of disruptive behavior or property destruction
- ☐ When presented with an instruction, non-compliance frequently occurs and consists of disruptive behavior or property destruction AND/OR non-compliance occasionally occurs and consists of aggressive or self-injurious behavior
- ☐ When presented with an instruction, non-compliance frequently occurs and consists of aggressive or self-injurious behavior

Does the patient engage in **elopement**? ☐ Yes ☐ No
If no, skip to the next box (regarding dangerous behaviors).

If yes, please indicate which of the following the patient engages in.

- ☐ Attempts to leave a confined area (e.g., room, house, etc.)
- ☐ Refuses to remain seated (e.g., wanders away during meals or stationary vocational work)
- ☐ Attempts to pull away from you/staff / run away in public
- ☐ Other:

How often does the patient engage in elopement?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the elopement by selecting one of the following

☐ Elopement involves slowly wandering away from caregivers and/or refusing to remain seated within a single room

☐ Elopement involves wandering away from caregivers to go to another room (within the same building)

☐ Elopement involves pulling away from caregivers and attempting to (or successfully) leaving the caregiver in public, but is easy to retrieve

☐ Elopement involves attempting to (or successfully) darting away from caregivers either in public or leaves a confided building and is difficult to retrieve/requires law enforcement to locate

Does the patient engage in **dangerous behaviors**? ☐ Yes ☐ No
If no, skip to the next box (regarding emesis and ruminations).

If yes, please indicate which of the following the patient engages in.

☐ Climbing on furniture	☐ Jumping on/off furniture	☐ Tipping furniture
☐ Standing on furniture	☐ Touching heating vents	☐ Touching stoves
☐ Touching electrical sockets	☐ Banging on windows	☐ Climbing on windowsills
☐ Other:	☐ Other:	☐ Other:

How often does the patient engage in dangerous behaviors?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the dangerous behaviors by selecting one of the following

☐ Dangerous behavior does NOT result in marks on the body or broken property

☐ Dangerous behavior occasionally results in reddening of skin, mild swelling, first-degree burns, or damage to property that is easily repaired

☐ Dangerous behavior frequently results in light scratches, small or shallow breaks in the skin, moderate to severe swelling, a second-degree burn, or damage to property that is difficult to repair

☐ Dangerous behavior results in scars, lasting tissue damage, disfigurement, a third-degree burn, or damage to property that is not possible to repair

Does the patient engage in **emesis and/or rumination**? ☐ Yes ☐ No
If no, skip to the next box (regarding ritualistic behavior).

If yes, please indicate which of the following the patient engages in.

☐ Emesis (vomiting)

☐ Rumination (bringing back up and/or re-chewing partially digested food that has already been swallowed)
☐ Other:

How often does the patient engage in emesis and/or rumination?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the emesis and/or rumination by selecting one of the following

☐ The patient engages in mild gagging behavior

☐ The patient occasionally engages in rumination and/or emesis that does NOT damage the esophagus, teeth, gums, or mouth

☐ The patient frequently engages in rumination and/or emesis that does damage the esophagus, teeth, gums, and/or mouth but does NOT lead to malnourishment, loss of consciousness, or hospitalization

☐ He patient frequently engages in rumination and/or emesis that does damage the esophagus, teeth, gums, and/or mouth AND has led to malnourishment (and/or need for a feeding tube), loss of consciousness, or hospitalization

Does the patient engage in **ritualistic behavior**? (Rigid routines that, when interrupted or unable to complete, can lead to challenging behavior) ☐ Yes ☐ No
If no, skip to the next section.

If yes, please describe some rituals that are particularly problematic.

How often does the patient engage in ritualistic behavior?

☐ Monthly ☐ Weekly ☐ 2-3 times per week ☐ Daily ☐ Hourly ☐ Multiple times per hour

Please rate the severity of the ritualistic behavior by selecting one of the following

☐ When presented with a disruption to a ritual, the patient may whine, cry, or vocally protest

☐ When presented with a disruption to a ritual, the patient frequently non-violently pushes caregivers or other out of the way AND/OR occasionally engages in disruptive behavior or property destruction

☐ When presented with a disruption to a ritual, the patient frequently engages in disruptive behavior or property destruction AND/OR occasionally engages in aggressive or self-injurious behavior that leads to minor injuries

☐ When presented with a disruption to a ritual, the patient frequently engages in aggressive or self-injurious behavior that leads to moderate-severe injuries

Please note any other problem behaviors the patient engages in below.

Have the patient's problem behaviors resulted in any of the following?

☐ Breaks to the skin leaving scars, broken bones, or lasting tissue damage to the patient

☐ Breaks to the skin leaving scars, broken bones, or lasting tissue damage to others

☐ Blows directed to own head resulting in concussions or other head trauma

☐ Blows directed towards others resulting in concussions or other head trauma

☐ Blows close to or contacting own eyes

☐ Blows close to or contacting other's eyes

☐ Emergency department visit by the patient

☐ Emergency department visit by others (e.g., after aggressive behavior)

☐ Hospitalization (e.g., on a psychiatric or neurobehavioral unit)

☐ Placement in a developmental center

☐ Involvement of law enforcement

☐ Consumption of sharp, contaminated, or toxic items

☐ Structural damage to furniture, walls, cars, etc.

☐ Running away from caregivers, out of sights, and difficult to retrieve

☐ None of the above

Does the patient currently have a Behavior Support Plan (BSP) in place?

☐ Yes ☐ No

*If yes, please send a copy of the BSP along with this form.

Section VII: Admission Information

Does the patient receive Medicaid? ☐ Yes ☐ No (if no, skip to the next box)	
State of Medicaid Program	Phone Number
Medicaid Member ID Number	
*For residence of New Jersey, is the patient approved to participate in the NJ DDD Supports Program? ☐ Yes ☐ No	

Does the patient receive private health insurance? ☐ Yes ☐ No (if no, skip to the next box)			
Insurance Company		Contact Number for the Plan	
Policy Holder's Name	Policy Holder's DOB	Policy ID Number	Policy Group Number
Policy Holder's Phone Number		Policy Holder's Address	

If admitted into the Intensive Outpatient Clinic, will the caregiver or other provider be able to provide transport to and from the Rutgers Center for Adult Autism Services? ☐ Yes ☐ No

Thank you for completing this form! Once you are finished, please submit this document (along with a current copy of the patient's Behavior Support Plan, if applicable) to ioc-referrals@rcaas.rutgers.edu.