

Iowa Regional Autism Assistance Program (RAP) Referral Form

Download form, fill out as completely as possible, save, then send copy by email or fax to:

Email: iowa-RAP@uiowa.edu Fax: (319) 384-6480

Questions? Call (866) 219-9119

Child's Information

Child's Name (First, Middle Initial, Last):		Today's Date:	
Date of Birth (mm/dd/yyyy):		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	
Address:			
City:		Zip:	County:
Home Phone:		Primary Language:	
Primary Care Provider (PCP):		PCP's City:	
Race (check one): <input type="checkbox"/> White <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaii/Pacific Islander <input type="checkbox"/> Multiracial <input type="checkbox"/> Unknown/Unspecified <input type="checkbox"/> Declined			
Ethnicity (check one): <input type="checkbox"/> Hispanic/Latino or Spanish Origin <input type="checkbox"/> Not Hispanic/Latino or Spanish <input type="checkbox"/> Unknown <input type="checkbox"/> Declined			

Parent or Guardian Information

1 st Parent/Legal Guardian:		2 nd Parent/Legal Guardian:	
Relationship to child:		Relationship to child:	
Cell Phone:		Cell Phone:	
Email:		Email:	
Address, if different from above (street, city, zip):		Address, if different from above (street, city, zip):	

Question(s)/Concern(s) to be Answered

<input type="checkbox"/> Family to family support <input type="checkbox"/> School support e.g. IEPs, 504s <input type="checkbox"/> Explore waiver, other funding options <input type="checkbox"/> Connect to community resources, providers	<input type="checkbox"/> CHSC clinical services - Autism screening to assess need for further evaluation <input type="checkbox"/> Other (please explain):
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Referral Source Information

Provider Name:		Role:	
Agency:			
Phone:		Email:	
Address (street, city, zip):			