RAP
Iowa Regional Autism Assistance Program

Referral 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, ext. 2

Referral Source Information

Name:	Date:
Agency:	Role:
Address:	City, Zip:
Email:	Phone:

Child's Information

Child's First Name:	Child's Middle Initial:	Child's Last Name:
Date of Birth: ___/ ___ /_____	Gender (M / F / Other):	
Address:	City:	Zip:
Home Phone:	Primary Language:	
Primary Care Provider:		

Patient's Race: (check one)
____ African American/Black
____ American/Indian/Alaska Native
____ Asian
____ Declined
____ Hispanic/Latino of any Race
____ Multiracial/Two or More Races
____ Native Hawaiian/Pacific Islander
____ Unknown/unspecified
____ White

Patient's Ethnicity: (check one)
____ Declined
____ Hispanic/ Latino or Spanish Origin
____ Not Hispanic/Latino or Spanish
____ Unknown

Parent or Guardian Information

1st Parent/ Legal Guardian, relationship to child:	2nd Parent/Legal Guardian, relationship to child:
Cell Phone:	Cell Phone:
Email:	Email:

Question(s)/Concern(s)

____ Family to family support
____ School support e.g. IEPs, 504s
____ Explore waiver, other funding options
____ Connect to community resources, providers
____ CHSC clinical services - Autism screening to assess need for further evaluation
____ Other (please explain):