Confirmation of Diagnosis

Child's Name: _____DOB: _____

Primary Care Physician: _____

Parent /Guardian Name: _____

Mailing address: _____
(Apt, number, street)

_____
(city/town/village) (zip code)

Telephone: _____

Parent/Guardian Signature: _____

Parental or guardian signature indicates agreement with the information provided and gives consent to be contacted by a Quincy Medical Group Foundation Great River Autism Connection committee member regarding services and gives permission for the diagnosing professional to disclose Confirmation of Diagnosis and diagnostic write-up to the Quincy Medical Group Foundation.

<u>This Part to Be Completed by Diagnosing Professional Only</u>

Profession: ☐ Physician: _____
(specialty)
☐ Psychologist
☐ Psychiatrist
☐ School Psychologist

Name: _____

Address: _____

Phone Number: _____

Diagnosis: ☐ Autism Spectrum Disorder (ASD)

Diagnostic Assessment Tools used:

_____

_____

_____

☐ Form completed by office staff on behalf of diagnosing professional.

Name and Role: _____

_____ _____
Name (please print) Date

_____ _____
Signature Date