

Inquiry for Services



WorkingWithAutism™
and pervasive developmental disorders

Date:	
Child Name:	
DOB:	
Diagnosis:	
Parent Names:	
Contact Information: Phone and email for parents/caretakers Who is the primary contact (point of contact)	
Age/Gender of Child:	
Funding Source: Insurance Carrier: Regional Center: School District:	
Address: Residence where services will take place	
Availability for Services: (days/times)	
Language capabilities of each family members and child: e.g., Does mother/father speak English, Spanish, or are they Bilingual, what about child?	
Behaviors/Concerns:	
Additional Information you would like to share with our Clinical Team:	

Working With Autism

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