Lighthouse Autism Center Referral Form

Provider Information

Provider Name: ____________________ Facility/Affiliate: _________________________

Phone: ___________________________ Fax: ________________________

Email: ____________________________ Referral Date: ______________________

Reason for referral: ____

Patient Information

Patient Name: ________________________________ Patient DOB: ________________________

Parent or Guardian Name: ________________________________

Address: _________________________________ City, State, Zip: _______________________

Phone: _________________________ Email: ______________________________

Please attach patient demographics and any other pertinent information to the fax

Lighthouse Autism Center Phone: 574-387-4313

Lighthouse Autism Center Fax: 574-217-4894