trueNorth
WELLNESS SERVICES
inspiring hope & healthy living

Please return this form to:
Stephanie Hann-Snyder
Family Liaison Supervisor
TrueNorth Wellness Services
1181 Westminster Ave.
Hanover, PA 17331

Office: (717) 632-4900 x 1559
Fax: (717) 969-8331
shannsnyder@truenorthwellness.org

Referral for Autism Services

Date _____/_____/_____

Service Requested:

☐ **Hanover Location** ☐ **Red Lion Location**

Referral Source

School/Agency Making Referral _____ _____

Address/Location_____

Contact Person(s)_____

Phone _____ Email:_____

Client Information

Child/Adolescents Name _____ D.O.B. ____/_____/_____

Home School District _____ _____ IEP/504 Plan? Yes No

Legal custody of child/adolescent ☐ Both parents ☐ Mother only ☐ Father only

Mother's Name _____ Phone _____
Address _____

Father's Name _____ Phone _____
Address _____

Is the child/adolescent involved with MH-IDD? Yes No
Case Manager _____ Phone _____

Reason for referral:

_____

_____

Intervention History (Brief treatment, partial placements, past hospitalizations, etc):

_____

_____

Other involved agencies:

___ Therapy/Counseling _____ ___ Psychologist _____
___ Children and Youth _____ ___ Psychiatrist _____
___ Probation _____ ___Other _____