Request for Services

Please return this form to our office.
Email and scan to: services@autismpartnership.com or mail/fax as listed below.

Child's Full Name: Today's Date:

Date of Birth: Current Age:

Home Address:
(Street) (City) (State) (Zip)

Parent Name: . Parent Name: .

Parent Home: (____) _____ Parent Home: (____) _____

Parent Cell: (____) _____ Parent Cell: (____) _____

Parent Email: _____ Parent Email: _____

Tell us about your child: (Comment on Social, Behavioral and Academic strengths and/or areas of concern)

Autism Partnership
200 Marina Drive * Suite C * Seal Beach * CA 90740 * (562) 431-9293 phone * (562) 431-8386 fax

If services have been authorized/funded, please complete the following:

Funded by (indicate): School District Regional Center Other

Contact: Phone: Ext. .

IEP/IPP was held on: _____/____/____

Indicate the specific services that have been authorized:

If services will be privately funded, who is responsible? .

Current services that are being provided (ABA at home or school, Speech, OT etc.):

Service: Provider: Frequency: .

Service: Provider: Frequency: .

Service: Provider: Frequency: .

Does your child attend school? Type of classroom .

School Name: .

School Phone: Grade Level: .

Child Attends (indicate): M T W Th F Mon – Fri

School start time: School end time: .

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Child's Full Name:

Optional Information Complete and submit if you wish

What treatments have you tried?

What are your goals for your child?

Questions, Concerns or Special Circumstances

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