AUTISM DIVISION
Referral for M-CHAT Follow-Up Interview and STAT

Note: Use this form only if the parent selected an Autism Division Assessment Specialist to complete the M-CHAT Follow-Up Interview. Once completed, send to the Autism Division by e-mail adstats@ddsn.sc.gov or FAX: (803)-545-4476.

Referral Date:_____ Date of Birth:_____

Child's Name:_____

Home Address:_____

Parent Name:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ County of Residence:_____

Parent Email:_____

Test Locations

Note: Please indicate the test location closest to the individual by checking the appropriate line below.

☐Coastal ☐Midlands ☐Pee Dee ☐Piedmont

Will an interpreter be needed to provide this service? ☐YES ☐NO

EI/Case Management Provider:_____

Address:_____

Name of EI/Case Manager Making Referral:_____

EI/Case Manager Phone Number:_____ Fax Number:_____

EI/Case Manager Email:_____