**KidsConnect Initial Registration Form**

Please complete all sections:

|  |  |  |
| --- | --- | --- |
| Today’s Date:  | Child’s Name:  | Gender:  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age: | Birthdate:  | Current Height:  | Current Weight:  | Diagnosing Physician:Phone/Fax:Diagnosis Given:Date of Diagnosis:  |
| Referred By:  | Primary Care Physician:Phone/Fax:  |

|  |
| --- |
|  |
| How does your child currently communicate? I.e. signs, gestures, sounds, single words, 2 word phrases, short sentences, longer sentences?  Please give an example of a typical use of communication. |

**Caregiver Contact Information**

|  |
| --- |
|  |
| **Parent/Caregiver 1** | **Parent/Caregiver 2** |
| Name: | Name: |
| Home Phone:  | Cell Phone: | Home Phone:  | Cell Phone: |
| Work Phone:  | Email:  | Work Phone:  | Email:  |

Please **EMAIL** this registration to the contactbelow:

**Annette Lovato**

KidsConnect

Resnick Neuropsychiatric Hospital at UCLA

760 Westwood Plaza, room 78-215

Los Angeles, CA 90024

**alovato@mednet.ucla.edu**

We will call you to confirm receipt of this form as well as to inform you that your child has been added to our waitlist.

Wishing you and your family well.

Thank you!
KidsConnect Autism Treatment Program