Autism Spectrum Disorder Diagnosis Form

Patient Name: ____

Date of Birth: ____

I am the (pediatrician / medical physician / developmental pediatrician / psychologist / psychiatrist) treating the above-referenced patient. At the present time, the above-referenced patient is currently diagnosed with an autism spectrum disorder of ___________________________________(i.e. ASD Level 1, 2 or 3).

Signature: ______________________________ Date: ____________________

Typed Name: ____

The above-referenced patient is applying for a therapy grant from The ISAAC Foundation. In order to qualify for financial assistance, the patient must provide medical documentation demonstrating that the patient's current diagnosis is an Autism Spectrum Disorder. Information provided in this **Autism Spectrum Disorder Diagnosis Form** is for the exclusive use of The ISAAC Foundation for grant eligibility. This information will not be disclosed unless specifically requested by a Law Enforcement Agency or as required by law.

Please return to:

The ISAAC Foundation
28 W. Third, Ste. B-1
Spokane, WA 99201