



PLEASE NOTE: We DO NOT accept referrals for the following ... Psychiatric Disorders, Issues Related to Custody Cases, or Parental Discord.

Date of Request: ____/____/____

Patient Name _____
Last First Middle

Interpreter services needed: Yes ☐ No ☐ if yes, which language:

Patient Date of Birth:	Age:	Sex:
Patient Street Address:		
Patient City:	State:	Zip: County:
Parents or Legal Guardian of Patient:		
Custody (please attach documentation if not in parental custody):		
Home Phone (Include Area Code):	Cell Phone:	
Work Phone:	E-mail:	
Primary Care Provider (PCP):		
PCP Phone:	PCP Fax:	
Referring Provider (if different from PCP):		
Referring Provider Phone:	Referring Provider Fax:	

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Policy Holder and Date of Birth:	Policy Holder and Date of Birth:
Policy/Group #:	Policy/Group #:
ID #:	ID #:
Insurance Co. Phone #:	Insurance Co. Phone #:
Employer:	Employer:



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NEW - In order to better serve your patients please complete all fields below- we will return the referral if left blank. Thank you

REFERRAL FOR: ☐ Developmental Pediatrics ☐ Evaluation only ☐ Evaluate and treat ☐ Applied Behavior Analysis (ABA) Therapy ☐ Occupational Therapy (OT) ☐ Speech Therapy (ST) ☐ Pediatric Feeding (PF) ☐ Physical Therapy (PT)	REASON FOR REFERRAL:
Developmental Pediatrics (18 Months – 5 Years)	
Date of last Vision test and results: _____ Date of last Hearing test and results: _____ Date of last Lead test and results: _____ Child is Currently Receiving ☐ ST ☐ OT ☐ PT ☐ None Developmental Delay ☐ Speech Delay ☐ Cognitive Delay ☐ Motor Delay ☐ Self Care Delay	Autism Spectrum Disorder ☐ New Eval / Interdisciplinary Eval (MD, OT, & SLP when eligible) ☐ Previous Diagnosis Social communication deficits? Yes ☐ No ☐ Repetitive-restricted behaviors? Yes ☐ No ☐ MCHAT Score: _____ Attention Deficit Hyperactivity Disorder ☐ ADHD – New Evaluation ☐ Previous Diagnosis ADHD Medications current or tried in the past: _____
Therapy Services (18 Months– 5 Years)	
Diagnosis and Provider Signature Required for Order: Diagnosis: _____ <i>(For patients willing/able to maintain weekly visits)</i> ☐ Speech Therapy ☐ Occupational Therapy ☐ Child is already receiving therapy or had an evaluation <i>(Please attach last evaluation since insurance may not cover if done within the last 6 months.)</i>	Medical Diagnoses: _____ Medications: _____ Therapy Providers/Clinic: _____ Psychiatric Hospitalizations: _____ Behavioral Health Providers: _____

Please Attach Current Progress Notes and/or Recent Therapy Evaluations associated with this referral.



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Behavioral Health/ABA Therapy (2 Years – 6 Years)

Diagnosis: _____

Assessment Tools Utilized to Inform Diagnosis (Check All that Apply)

- ☐ Autism Symptoms: ADOS-2/STAT/GARS-3/CARS
☐ Adaptive Skills: ABAS-2/Vineland-3
☐ Cognitive Tests: _____
☐ Genetic Tests
☐ Other: _____

Reason for Referral (Check All That Apply)

- ☐ Challenging Behavior
☐ Health and Safety Concerns
☐ Communication Concerns
☐ Social/Emotional Concerns
☐ Adaptive Living Skills
☐ Caregiver Coaching/Support
☐ Feeding Concerns
☐ Other: _____

Please attach a copy of diagnostic evaluation with recent clinical updates supporting medical necessity of ABA Services.

This is frequently required for initial authorization.

Please Attach Current Progress Notes, Diagnostic Results, or Recent Therapeutic Evaluations/Recommendations associated with this referral.

Referring Provider Signature: _____ **Office Phone:** _____

Print name: _____ **Office Fax:** _____

