PLAY-BASED WELLNESS

REFERRAL FORM: PLEASE FAX TO: 1 469 242 9708

Child's Information

Child's Name: _____ Child's Date of Birth: _____

Gender: _____ Date of Diagnosis Eval: _____

Does the child have an Autism Spectrum Diagnosis? (Y/N): ☐ Yes ☐ No

Any other Diagnoses? If so, please list: _____

Primary Insurance

Name of Subscriber: _____ Medicaid Policy (Y/N): _____

Insurance Company: _____ Policy/Member ID: _____

Group Number: _____ Relation to Child: _____

Subscriber DOB: _____

Secondary Insurance

Name of Subscriber: _____ Medicaid Policy (Y/N): _____

Insurance Company: _____ Policy/Member ID: _____

Group Number: _____ Relation to Child: _____

Subscriber DOB: _____

Caregiver Information

Primary Contact: _____ Cell Phone: _____

Email: _____ Preferred Method of Communication: ☐ Phone ☐ Email

Patient's Address:

Ordering Physician Information

Name of Physician: _____ License Type (MD, etc.): _____

Phone Number: _____ Fax: _____

Organization Name: _____

I hereby refer the above-named patient for Applied Behavior Analysis (ABA) therapy services. I have determined that ABA therapy is medically necessary for the treatment of the patient's diagnosed condition.

Physician Signature: _____ Date: _____