




INDIVIDUALIZED BEHAVIORAL SERVICES FOR YOUR CHILD

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ABA THERAPY REFERRAL

Please fill out the following information and submit this form along with the available supporting documents stated below.

Date of Referral: _____

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____ Practice Name: _____

Phone Number: _____ Fax Number: _____ Email: _____

CLIENT'S INFORMATION

Name: _____ DOB: _____ Age: _____ Gender: _____

- Diagnosis:
- F84.0 – ASD (AUTISM)
 - F90.2 – ADHD, Attention-deficit hyperactivity disorder, combined type.
 - F90.1 – ADHD, Attention-deficit hyperactivity disorder, predominantly hyperactive type.
 - F90.0 – ADHD, Attention-deficit hyperactivity disorder, predominantly inattentive type.
 - F84.9 – PDD, Pervasive developmental disorder, unspecified
 - Q90.9 – Down syndrome, unspecified.
 - Q90.0 – Trisomy 21, nonmosaicism (meiotic nondisjunction)

PARENT/GUARDIAN CONTACT INFORMATION

Name: _____ Relationship: _____

Phone: _____ Email: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy holder: _____

SUPPORTING DOCUMENTATION CHECKLIST

Please checkmark the documents submitted with this referral form.

- Letter of Necessity Physician Assessment with behavioral intervention prescription code and diagnosis
- Diagnosis Assessment/Neurological Assessment Individualized Educational Plan (I.E.P.) / Early Steps Evaluation

Thank you for referring your patient to Coral Behavioral Services.