




INDIVIDUALIZED BEHAVIORAL SERVICES FOR YOUR CHILD

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CLIENT INTAKE FORM

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: _____

Recipient #: _____ Diagnosis: _____ SSN: _____

PARENT/GUARDIAN CONTACT INFORMATION

Name: _____ Relationship: _____

Phone: _____ Email: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy holder: _____

SUPPORTING DOCUMENTATION CHECKLIST

Please checkmark the documents submitted with this referral form.

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

Thank you for referring your patient to Coral Behavioral Services.