REFERRAL FORM--BEHAVIOR ANALYSIS SERVICES

Date of referral	
Referral Source name, number, email	
Child's Name	
Child DOB	
Child Age	
Child Gender	
Child SS#	
Insurance ID#	
Does child have DCF/DCM? If so, list name and agency	
Child Home Address	
Child Resides with	
Parent/Caregiver Name	
Parent/Caregiver contact number/email	
List other service providers, including name, agency and contact phone numbers	
Child's primary care physician	
Child's Diagnosis (must be a qualifying/specific Axis I diagnosis)	
Reason for referral	
Behaviors of concern	
Outcomes anticipated	
School/Daycare Name & Contact Person & Number	
	Include copy of evaluation for referring diagnosis

Notes: In order to receive Behavior Analysis services from Behavior Basics through Medicaid Insurance, all the requested information is needed to get the service authorized. The physician (MD) must provide a prescription for ABA services. A copy of a comprehensive diagnostic evaluation on the referred child must be submitted as well to verify diagnosis and clinician rendering diagnosis.

*Return completed forms: info@behaviorbasicsinc.com or fax: 772-219-1339