ABA THERAPY REFERRAL FORM

PATIENT INFORMATION

❑Male ❑Female (Gender assigned at birth)

Last | First | Middle

Street Address | Apartment number

City | State | Zip

Date of Birth | Diagnosis (e.g. Autistic Disorder) | Date of Diagnosis

Patient's Diagnosis Code (e.g. F84.0) | Diagnosis Severity (per DSM-5 Diagnostic Criteria) ❑Level 1: Requiring support ❑Level 2: Requiring substantial support ❑Level 3: Requiring very substantial support

PRIMARY GUARDIAN INFORMATION

Last | First | M.I.

Street Address | Apartment number

City | State | Zip

Relationship to Client | Primary Phone Number ( ) | Email Address

Date of Birth | Employer | Social Security Number - -

Preferred Language

PATIENT INSURANCE INFORMATION

Primary Insurance Company | Member ID Number | Group Number

Policyholder Name | Policyholder Date of Birth | Relationship to Patient

Secondary Insurance Company | Member ID Number | Group Number

❑Yes ❑No
State Funded Insurance? | Name of State Fund | State Plan ID Number

PATIENT BEHAVIOR

Please check any and all concerns that apply to the patient and please explain on the line below:

❑Communication	❑Verbal Aggression	❑Self-injury	❑Cognitive Skills
❑Pre-verbal	❑Physical Aggression	❑Dangerous Behavior	❑Community Participation
❑Non-verbal	❑Property Destruction	❑Social Skills	❑Play/Leisure Skills

REFERRING PHYSICIAN INFORMATION

Physician Printed Name | Phone Number ( ) | Fax Number ( )

Physician's Signature | Date

HOW DID YOU HEAR ABOUT THRIVE ADVANCED CARE?

Please check all that apply:

❑Google Search	❑Insurance	❑Brochure	❑Presentation
❑Website	❑Word-of-Mouth	❑Event/Community Booth	❑Mailer
❑Mailer	❑School District	❑Physician	❑Other Social Media_____

This form is to be completed and submitted to Thrive Advanced Care, LLC. Fax completed form to (972) 441-8936 or email to info@thriveadvancedcare.com. Call (972) 441-8936 if you have any questions or concerns.

Thrive Advanced Care, LLC
972-441-8936
www.thriveadvancedcare.com