Autism & Behavior Services
Referral Form

Directions: To make a referral for ABA therapy, please fill out the information below and fax the sheet to (423)602-9710.

Please Include:

- ❑ Copy of insurance card (front & back)
- ❑ Copy of doctor's order for ABA, including client's name, date of birth, diagnosis, and signed by MD

Child's Name: ________________________ DOB: ________________ Gender: M___ F___

Address: ____

City: ________________________________ State: ______ Zip: __________

Parent(s)/Guardian(s)Name**:**

(1):__________________________________ Relation to Child: ______________

Phone: ______________ Cell:______________ Email: ____________________

(2):__________________________________ Relation to Child: ______________

Phone: ______________ Cell:______________ Email: ____________________

Primary INS Information: ______________________________________

Secondary INS Information: ____________________________________

Diagnosis: ____

Referred by: ____

Reason for referral:

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For admin use:

Date and time of initial consultation ______________
Date and time of phone consultation ______________
Entered into database____ __________________

4.12.19