



ABA Referral Form

Date of Referral:		Name of Person Receiving Referral:	
REFERRING PERSON			
Name:		Agency:	
Role:		Location:	
City:		Phone:	
State:		Fax:	
Email:			
CLIENT DEMOGRAPHIC INFORMATION			
Name:	DOB:	Age:	Gender:
SSN:		Pronouns:	
Street Address:			
City:		State:	Zip:
Cell Phone:		Home Phone:	
Email Address:			
Preferred Method of Contact (cell phone, home phone, or email):			
School Attending:		Grade:	
IEP/Special Ed Program?		If yes, Category of Disability:	
Does the client have a diagnosis?		If yes, describe:	
Who is the client's Primary Health Physician?			
Which practice are they located at?			



Primary Physician's Phone:	Fax:
Who is the best person to reach out to for diagnostic confirmation or a diagnostic report?	
Is/was verbal consent given by the guardian to contact the medical providers listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
LEGAL GUARDIAN / CAREGIVER INFORMATION	
Primary Guardian's Name:	
Street Address:	
Cell Phone:	Home Phone:
Email:	
Preferred Method of Contact (cell phone, home phone, or email):	
Emergency Contact:	
Relation to Client:	Phone:
Email:	
INSURANCE / PAYMENT INFORMATION	
Commercial Policy? <input type="checkbox"/> Y <input type="checkbox"/> N	Medicaid #:
Primary Insurance (MCO):	ID:
Subscriber Name:	DOB:
Secondary Insurance (MCO):	ID:
Subscriber Name:	DOB:
SUMMARIZE THE REASON FOR THE REFERRAL:	
Client's Identified Needs and Areas of Concern the Family Would Like Support With:	

Diagnosis:	
Current Medications:	
Allergies and Severity (mild, moderate, severe):	
General Availability (During school year & Summer):	
IN-CLINIC SESSIONS	
Availability: Do you have reliable transportation?: <input type="checkbox"/> Y <input type="checkbox"/> N	
Food Sensitivities/Concerns:	
IN-HOME SESSIONS	
Availability:	An adult (18+) must always be present & available for in-home sessions. Does this align with your current availability?
Are you able to provide a therapeutic space to conduct ABA therapy? This should include available seating for the client & technician, as well as a surface to complete tasks on.	
Are there any pets at home?	
Are there any religious or cultural practices to be mindful of in your home?	
Any other information regarding the home environment you would like to provide?	



Please return this form to:

Email: scheduling@autismfirstus.com

Fax: (703) 435-4021

ADDITIONAL NOTES FOR SCREENER:

COMMERCIAL INSURANCES: Will require an ASD (Autism) diagnosis & a full diagnostic report.