380 Polk Street | Greenwood, IN 46143
PH 317.888.1557 | FX 317.888.1571

Physician Referral for ABA Therapy

Today's Date _____/_____/_____

Physician Name: ____ Office Name: ____

Address: ____ Phone: ______________________ Fax: ______________________

Parent/Guardian Contact

Name ___________________________________ Phone: _____________________ Email: _____________________________________

Child Information

Child's Name ____ DOB ____/_____/_____ Age: ________ Sex: M F

DX:____

ICD-10:____

Reason for Referral: ____

Please check areas of concern:

- □ Cognitive / Intellectual Functioning
- □ Academic Abilities and Functioning
- □ Speech and Language Development
- □ Social Development
- □ Emotional Development
- □ Behavioral Functioning
- □ Adaptive Functioning
- □ Not meeting developmental milestones

Has the child been diagnosed with any of the following, please explain:

- □ Genetic Disorder: ___________________________
- □ Metabolic Disorder: __________________________
- □ Seizure Disorder: ____________________________
- □ Congenital Disorder: _________________________
- □ Other Medical Illness/ Disorder: _______________

Current Medications: ____

____

This will serve as a Letter of Medical Necessity and referral for the above referenced patient to receive:

□ ABA Therapy, 35 hours per week ____

Physician Signature: ____ Date: _____________________

Please fax this form to: Vicki Moyer, Intake Coordinator at: 317-888-1571.