Spring
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Phone (713) 962-4599 | Fax (281) 783-2839
Memorial
6955 Portwest Drive, Suite 190, Houston, TX 77024
Phone (832) 740-1100 | Fax (281) 783-2839
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ABA Therapy Referral

Patient Name:	Date of Birth: ____ /____ /_________	
Parent/Guardian Name:	Phone 1:	Phone 2:

Diagnostic Practitioner Name:	
NPI#: Telephone #:	Fax #:
Contact Name at Office:	Add'l Phone Number:

Diagnostic Practitioner Type (1) PCP: Family Practice ☐ Internal Medicine ☐ Pediatrics ☐
or (2) Specialized ASD-Diagnosing Providers: Developmental Behavioral Pediatrics ☐ Neurodevelopmental Pediatrics ☐
Child Neurology ☐ Adult or Child Psychiatry ☐ Licensed Clinical Psychology, Doctoral level ☐
☐ Other, specify: ____

Primary Dx Code #:	Secondary Dx Code:
Other DX Codes:	Date of Evaluation: ____ /____ /_________

Assessment Instrument(s), please check/list as appropriate: ADOS___ ABC ____ CARS ___ M-CHAT ___ CSBS-DP-IT Checklist _____

OSI ___ ASQ ___ AQ ___ AQC _____ CAST ____ ASDS ___ GADS ___ ASDI ___ SRS ___ ADI-R ___ VABS-2 ______

Other: ____

Comments:

I certify after my evaluation, this patient has a diagnosis of Autism Spectrum Disorder (ASD).

Diagnostic Physician/Specialist Signature : ______________________________ Date: ____ / ____ / _________

☐ **I am recommending ABA services**, certify there is a reasonable expectation that this member can actively participate and demonstrates the capacity to learn and develop generalized skills to assist in his/her independence and functional improvements.

Please Send **This Form** Along with **Diagnostic Assessment Report** and Relevant Patient Information to:

Fax: (281) 783-2839 Email: Info@ActionBehavior.com

Please call our admin or clinical team at (713) 962-4599 with any questions