



Collaborative ABA Services, LLC

Referral Form

Child's First and Last Name:	
Date of Birth:	Gender:
Address:	Phone Number:
City: State: Zip code:	Referring Physician/Provider:
Medicaid ID #:	Health Insurance Plan: ID #:
Pets? Yes <input type="checkbox"/> No <input type="checkbox"/> How Many?	What Kind?

Parent/Legal Guardian First and Last Name:	Phone Number:
Address:	Email:
City: State: Zip code:	Primary Language:
Relationship to Child:	

Parent/Legal Guardian #2 First and Last Name:	Phone Number:
Address:	Email:
City: State: Zip code:	Primary Language:
Relationship to Child:	

Referral Source: <input type="checkbox"/> Agency <input type="checkbox"/> Physician <input type="checkbox"/> School <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Provider	
Contact Name:	Phone Number:
Diagnosis of Child:	
Reason for Referral:	
Service(s) Requested: <input type="checkbox"/> Diagnostic Evaluation <input type="checkbox"/> In-Home ABA Therapy <input type="checkbox"/> Other:	



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Permission Statement

"I _____ (Parent/Caregiver Name) give the referring agency/person permission to exchange and receive protected health information with Collaborative ABA Services, LLC regarding the individuals listed in this referral. The information will be used to determine eligibility for services and behavioral health treatment. I understand that my authorization is voluntary."

Parent/Guardian Signature: _____ Date: _____

***Parent/Guardian Permission is required for Referrals. If Parent/Guardian is unable to sign the referral form, please indicate referral source has permission from Parent/Guardian to submit referral by completing below:**

"I _____ (Name of person/agency representative making referral) have permission from Parent/Guardian to submit this referral on their behalf."

Referring Source Signature: _____ Date: _____