You First Health Systems

ABA Service Referral Form

Person Completing Form: Date:

I. REFERRAL SOURCE: Must be completed by a Clinical Psychologist, Nurse Practitioner, Neuropsychologist, Pediatrician, Developmental Pediatrician, Pediatric Neurologist, or Child Psychiatrist

Name of Person Making Referral:

Address:

Phone #:

Signature: Date:

II. CLIENTS INFORMATION:

First Name: Last Name:

Age: Date of Birth (mm/dd/yyyy): Gender ◯ M ◯ F

Address:

City: State: MD County: USA Zip Code:

Private Insurance ☐ Medicaid ☐ More than one insurance? ☐ Yes ☐ No

Insurance ID/Member #: Insurance Carrier:

Medicaid will be an 11-digit number

Insurance ID/Member #: Insurance Carrier:

Which insurance is primary?

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III. DIAGNOSIS INFORMATION:

Does the client have a Comprehensive Diagnostic Evaluation *CDE*? Yes ◯ No ◯ Date of CDE:

Clients Current Diagnosis:

Reason for Referral:

**Please request that CDE and/or referral form be emailed to info@youfirsthealthsystems.com OR fax to 301-825-9777*

IV. OTHER SERVICES CLIENT IS CURRENTLY RECEIVING:

Autism Waiver Services ☐ ABA Services ☐ Speech Therapy ☐ Occupational Therapy ☐

Other Service (*please specify*):