



AbleMinds
ABA

Referral Form

This form is to be completed and submitted to Able Minds ABA by developmental pediatricians and other qualified providers (physicians, physician's assistants, psychologists, and nurse practitioners) who have experience and training in the diagnosis of an Autism Spectrum Disorder.

Individuals must have a medical diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder that has been substantiated with a comprehensive assessment.

Patient Demographic Information

Child's Name: _____

Child's DOB (mm/dd/yyyy): ____/____/____

Parent/Guardian Full Name: _____

Contact Phone Number: ____ - ____ - ____

Contact Email: _____

Home Address: _____

Patient Insurance Information

Primary Insurance Name: _____

Member ID: _____

Subscriber's Name: _____

Subscriber's DOB (mm/dd/yyyy): ____/____/____

Secondary Insurance Name: _____

Member ID: _____

Subscriber's Name: _____

Subscriber's DOB (mm/dd/yyyy): ____ / ____ / ____

Other Insurance: _____

Referring Doctor Information

Doctor's Full Name: _____

NPI: _____

Practice Name: _____

Practice Address: _____

Practice Phone: ____ - ____ - ____

Practice Fax: _____

Practice Email: _____

Contact Name: _____

Clinical Information

Client's Diagnosis Code (e.g. F84.0): _____

Client's Diagnosis Description (e.g. Autistic Disorder): _____

Date of Diagnosis (mm/dd/yyyy): ____ / ____ / ____

Diagnostic Severity (per DSM-5 Diagnostic Criteria):

Level 1: Requiring Support

- Level2:RequiringSubstantial Support
- Level3:RequiringVery Substantial Support

ReasonforReferral(check all that apply; describe what problem behavior looks like & how often it occurs):

- Physicalaggression/describe _____
- Verbalaggression/describe _____
- Propertydestruction/describe _____
- Self-injury/describe_____
- Elope/Dangerousbehavior / describe _____
- CommunicationNeeds:
 - Verbal Pre-Verbal Non-Verbal

Other/describe: _____

Where does problem behavior occur?

- Home School Community Therapy / Medical Appointments

Signature

Physician's Signature: _____

Print Name: _____

Date: ____/____/____

**By signing above, I am ordering ABA services to be performed by Able Minds ABA.*

Please fax or email this order for ABA Assessment to:

(888) 846-7128

-or-

intake@ablemindsaba.com