## ABA THERAPY PRESCRIPTION & REFERRAL FORM

**Please fill this form to the best of your ability (fields that are unknown can be left blank).**

Child's Name: ____________________________________________

Gender: ________________ DOB: _______________________

Primary Care Physician: _________________________

Diagnosis and ICD -10 Code: ________________________________

Diagnosis date: ______________

Parent/guardian's name: ______________________________________________

Phone #: _______________________________________

Primary Email: _______________________________________

Home Address: __________________________________________

Primary insurance: ________________________________________

Policy #: ______________________________

Primary insurance holder & DOB: _______________

Secondary insurance: _________________________

Policy #: ______________________________

Symptoms exhibiting: ___________________________________________________________

Referring Physician: _________________________________ Credentials:________________

**Signature: _________________________________________Date: _________________**

**When signed by a licensed physician, this form acts as a prescription for ABA therapy services.**

**Please fax this form along with any relevant medical information to 877-745-4345**