



DIAGNOSIS | TREATMENT | SUPPORT
for Children with Special Needs - Since 1950

- NASHVILLE -

PROVIDER REFERRAL FORM
Please Complete Entire Form
FAX to 1.888.599.0828 (Referrals Only)

PLEASE NOTE: We DO NOT accept referrals for the following ... Psychiatric Disorders, Issues Related to Custody Cases, or Parental Discord.

Date of Request: ____/____/____

Patient Name _____
Last First Middle

Interpreter services needed: Yes No if yes, which language:

Patient Date of Birth:	Age:	Sex:
Patient Street Address:		
Patient City:	State:	Zip: County:
Parents or Legal Guardian of Patient:		
Custody (please attach documentation if not in parental custody):		
Home Phone (Include Area Code):	Cell Phone:	
Work Phone:	E-mail:	
Primary Care Provider (PCP):		
PCP Phone:	PCP Fax:	
Referring Provider (if different from PCP):		
Referring Provider Phone:	Referring Provider Fax:	

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Policy Holder and Date of Birth:	Policy Holder and Date of Birth:
Policy/Group #:	Policy/Group #:
ID #:	ID #:
Insurance Co. Phone #:	Insurance Co. Phone #:
Employer:	Employer:



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NEW - In order to better serve your patients please complete all fields below- we will return the referral if left blank. Thank you

<p>REFERRAL FOR:</p> <p>Developmental Pediatrics Evaluation only Evaluate and treat</p> <p>Applied Behavior Analysis (ABA) Therapy</p>	<p>REASON FOR REFERRAL:</p>
<p>Developmental Pediatrics (18 Months – 5 Years)</p>	
<p>Date of last Vision test and results: _____</p> <p>Date of last Hearing test and results: _____</p> <p>Date of last Lead test and results: _____</p> <p>Child is Currently Receiving</p> <p>ST OT PT None</p> <p>Developmental Delay</p> <p>Speech Delay Cognitive Delay Motor Delay Self Care Delay</p>	<p>Autism Spectrum Disorder</p> <p>New Evaluation Previous Diagnosis</p> <p>Social communication deficits? Yes No Repetitive-restricted behaviors? Yes No</p> <p>MCHAT Score: _____</p> <p>Attention Deficit Hyperactivity Disorder</p> <p>ADHD – New Evaluation Previous Diagnosis</p> <p>ADHD Medications current or tried in the past: _____ _____</p>
<p>Therapy Services (18 Months – 12 Years)</p>	
<p>Diagnosis and Provider Signature Required for Order:</p> <p>Diagnosis: _____ <i>(For patients willing/able to maintain weekly visits)</i></p> <p>Child is already receiving therapy or had an evaluation <i>(Please attach last evaluation since insurance may not cover if done within the last 6 months.)</i></p>	<p>Medical Diagnoses: _____</p> <p>Medications: _____</p> <p>Therapy Providers/Clinic: _____</p> <p>Psychiatric Hospitalizations: _____</p> <p>Behavioral Health Providers: _____</p>

Please Attach Current Progress Notes and/or Recent Therapy Evaluations associated with this referral.



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Behavioral Health/ABA Services (18 months – 12 Years)	
<p>Diagnosis: _____</p> <p>Assessment Tools Utilized to Inform Diagnosis (Check All that Apply)</p> <p>Autism Symptoms: ADOS-2/STAT/GARS-3/CARS Adaptive Skills: ABAS-2/Vineland-3 Cognitive Tests: _____ Genetic Tests _____ Other: _____</p>	<p>Reason for Referral (Check All That Apply)</p> <p>Challenging Behavior Health and Safety Concerns Communication Concerns Social/Emotional Concerns Adaptive Living Skills Caregiver Coaching/Support Other: _____</p>

Please attach a copy of diagnostic evaluation with recent clinical updates supporting medical necessity of ABA Services.

This is frequently required for initial authorization.

ADDITIONAL NOTES: _____

Please Attach Current Progress Notes and/or Recent Therapy Evaluations associated with this referral.

Referring Provider Signature: _____ **Office Phone:** _____

Print name: _____ **Office Fax:** _____