COLLABORATIVE CARE
Behavioral Therapy
LLC

Referral Form

Please complete the information below to refer a patient to our office for ABA evaluation and treatment.
Fax to: **(833) 409-2205**

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Patient/Client Information			
Last Name:		First Name:	MI:
Street Address			
City:	State:	Zip:	County:
Age: years months		Date of Birth:	
Parent/Guardian Full Name:		Phone:	
Parent/Guardian Full Name:		Phone:	
Primary Insurance Carrier:		Secondary Insurance Carrier:	
Any other information you think would be helpful to our evaluation and treatment of this patient:			

Referring Physician/Diagnostic Information			
Referring Physician:			
Phone:	Fax:	E-mail:	
Office Street Address:			
City:	State:	Zip:	County:
Diagnoses:			
***Note: In order to bill insurance, a diagnosis of Autism Spectrum Disorder (F84.0) must be listed for the patient.*			
Primary Diagnosis:		Diagnosing Physician:	
Date of Diagnosis:			
Secondary Diagnosis:		Diagnosing Physician:	
Date of Diagnosis:			
Other Conditions: *Include date of diagnosis and any information you think we would find helpful in the child or client's treatment.*			

To complete the referral, please attach the following:

- Service Order (from PhD, PsyD, MD, DO, CNP) for ABA therapy
- Autism Diagnosis and Supplemental Documentation
  i.e., ADIR, ADOS, CARS, GARS

Thank you for your referral and trust in treating your patient! We will be in touch with the patient's family soon!

bmcdonald@ccbt.services | (937) 441-1782