ABA Therapy Referral Form

Select Clinic: ❑Clemmons ❑Greensboro ❑Greenville ❑Wilmington ❑Boone ❑Ashe

Date of Referral:	Parents aware of referral (Y/N):
Background Information	
Client Name:	Date of Birth:
Client Address:	
Phone:	Email:
Guardian Name(s):	
Referral Information	
Referring Physician:	NPI:
Practice Name:	
Fax Number:	Callback Phone:
Diagnosis Code(s):	
Insurance Information	
Primary Insurer:	Member ID:
Secondary Insurer:	Member ID:

PLEASE SEND A COPY OF CONSENT TO RELEASE INFORMATION, COPY OF DIAGNOSTIC EVALUATION FOR AUTISM & RELATED ENCOUNTER FORM/VISIT NOTE(S) ALONG WITH THIS COMPLETED REFERRAL FORM TO THE FOLLOWING:

FAX: 252-565-4505 or **EMAIL**: INTAKE@BCPS-AUTISM.COM