# 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