Autism & Behavioral Spectrum

14733 Clayton Road
Chesterfield, MO 63011
314-339-7732

ABA Therapy Referral

PATIENT INFO		
Patient Name:	Date of Birth: ____ /____ /_____	
Parent/Guardian Name:	Phone 1:	Phone 2:

DIAGNOSTIC PRACTITIONER INFO	
Diagnostic Practitioner Name:	NPI#:
Telephone #:	Fax #:
Contact Name at Office:	Add'l Phone Number:

Diagnostic Practitioner Type (1) PCP: Family Practice ☐ Internal Medicine ☐ Pediatrics ☐

or (2) Specialized ASD-Diagnosing Providers: Developmental Behavioral Pediatrics ☐ Neurodevelopmental Pediatrics ☐ Child Neurology ☐ Adult or Child Psychiatry ☐ Licensed Clinical Psychology, Doctoral level ☐

☐ Other, specify: _____

DIAGNOSTIC INFORMATION	
Primary Dx Code #:	Secondary Dx Code:
Other DX Codes:	
Current IQ: (if known)	Date of Evaluation: ____ /____ /_____

Assessment Instrument(s), please check/list as appropriate: ADOS____ ABC ____ CARS ____ M-CHAT ____ CSBS-DP-IT Checklist ____

OSI ____ ASQ ____ AQ ____ AQC ____ CAST ____ ASDS ____ GADS ____ ASDI ____ SRS ____ ADI-R ____ VABS-2 ____

Other: _____

Comments:

I certify after my evaluation, this patient has a diagnosis of Autism Spectrum Disorder (ASD).

Diagnostic Physician/Specialist Signature : _____ Date: ____ / ____ / _____

☐ **I am recommending ABA services**, certify there is a reasonable expectation that this member can actively participate and demonstrates the capacity to learn and develop generalized skills to assist in his/her independence and functional improvements.

Please Send **This Form** Along with **Diagnostic Assessment Report** and Relevant Patient Information to:

Fax: (636) 220-8338 Email: Info@ABSpectrum.org

Please call our admin or clinical team at (314) 339-7732 with any questions.