This form is to be completed and submitted to All Kids Therapy by only developmental pediatricians and other providers (physicians, physician's assistants, psychologists and nurse practitioners) who have experience and training in the diagnosis of an Autism Spectrum Disorder. (Forms received from any other type of provider cannot be processed.)

Individuals must have a medical diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder that has been substantiated with a comprehensive assessment.

Patient Demographic Information

Child's Name: _____
Child's DOB (mm/dd/yyyy): ____/____/_____
Parent/Guardian Full Name: _____
Contact Phone number: _____-_____-_____
Contact Email: _____
Home Address: _____

Patient Insurance Information

Primary Insurance Name: _____
Member ID: _____
Subscriber's Name: _____
Subscriber's DOB (mm/dd/yyyy): ____/____/_____

Secondary Insurance Name: _____
Member ID: _____
Subscriber's Name: _____
Subscriber's DOB (mm/dd/yyyy): ____/____/_____

Other Insurance: _____

Referring Doctor Information

Doctor's Full Name: _____
NPI: _____
Practice Name: _____
Practice Address: _____
Practice Phone: _____-_____-_____
Practice Fax: _____
Practice Email: _____
Contact Name: _____

All Kids Therapy
3401 NW 34th St
Gainesville, FL 32605

Phone: (352)-380-1727 Fax: (866)641-6815
Website: www.allkidstherapycenter.com

Clinical Information

Client's Diagnosis Code(e.g. F84.0): _____
Client's Diagnosis Code (e.g. Autistic Disorder): _____
Date of Diagnosis (mm/dd/yyyy): ____/____/_____
Diagnostic Severity (per DSM-5 Diagnostic Criteria):

___Level 1: Requiring Support
___Level 2: Requiring Substantial Support
___Level 3: Requiring Very Substantial Support

REASON FOR REFERRAL (*Check all that apply; describe **WHAT** problem behavior looks like & **HOW OFTEN** it occurs)

- ❑ **Physical aggression/describe**
- ❑ **Verbal aggression/describe**
- ❑ **Property destruction/describe**
- ❑ **Self-injury/describe**
- ❑ **Elope/Dangerous behavior/describe**
- ❑ **Communication Needs:**
- ❑ **Feeding issues**
- ❑ **Verbal:**
- ❑ **Pre-Verbal:**
- ❑ **Non-Verbal:**

Other/describe:
Where does problem behavior occur? ___home ___school ___community ___therapy/medical appointments

Physician's Signature:_____

Print Name:_____

Date:____/____/_____

By signing above, I am ordering ABA services be performed by All Kids Therapy .
Please fax or email this order for ABA Assessment to: (352)-380-1727 or intake@allkidstherapycenter.com

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