

Client Intake Form for ABA Therapy

Thank you for referring your patient to Diversified Autism Behavioral Clinics for ABA Therapy. Please fill out the following information and submit via fax or email. If possible, please also attach the Supporting Documentation listed below. We will call you to confirm receipt of this referral.

Fax: (406) 894-2004 or Email: intakes@diversifiedautismclinics.com

Date of referral: _____

Name of physician submitting referral: _____

Clinic/practice name: _____

Clinic phone: _____ Clinic fax: _____

Clinic contact: _____

Patient Information

Patient Name: _____ Patient DOB: _____

Gender: ☐ Male ☐ Female

Parent/Guardian Name(s): _____

Parent/Guardian Contact Info

Email address: _____

Home address: _____

Home phone number: _____ Cell phone number: _____

Insurance Information

Primary insurance: _____ Policy holder: _____

Supporting Documentation Checklist

☐ The patient's comprehensive diagnostic evaluation (if available) that includes standardized testing and scores signed by a physician (MD/DO) or a clinical psychologist.

☐ A referral for therapy that is signed by a physician and includes a diagnosis code for autism spectrum disorder (F84.0).

☐ All information is contained on the submitted documents.