FIVE COUNTY AREAS
Office: 252-572-2933 Fax: 252-572-4745

Physician Referral for ABA Therapy

Today's Date_____/_____/_____

Physician Name:_____Office Name: _____

Address: _____ Phone:_____ Fax:_____

Parent/Guardian Contact

Name_____ Phone:_____Email: _____

Child's Name_____ DOB_____/_____/_____Age:_____Sex: M F

DX:_____

ICD-10:_____

Reason for Referral: _____

Please check areas of concern:

- □ Cognitive / Intellectual Functioning
- □ Academic Abilities and Functioning
- □ Speech and Language Development
- □ Social Development
- □ Emotional Development
- □ Behavioral Functioning
- □ Adaptive Functioning
- □ Not meeting developmental milestones

Has the child been diagnosed with any of the following, please explain:

- □ Genetic Disorder: _____
- □ Metabolic Disorder: _____
- □ Seizure Disorder: _____
- □ Congenital Disorder: _____
- □ Other Medical Illness/ Disorder: _____

Current Medications:_____

_____

This will serve as a Letter of Medical Necessity and referral for the above referenced patient to receive:

ABA Therapy,_____**hours per week**

Physician Signature:_____ Date: _____

Please fax this form to: Lakiesha Perkins-Tabron, Program Director at: 252-572-4745