Old Town ABA Referral Form
Phone: 703-952-1242
Fax: 571-410-0207
Winchester, VA based company serving the state of Virginia
referrals@oldtownaba.com
oldtownaba.com

Individual Making Referral

Individual Making Referral:
Address of Individual Making Referral:
Phone Number of Individual Making Referral:
Fax:
Email:
Relation to Individual:
Who referred you to us?

Service Funding Source and Services Requested

Requested Services

___ Therapeutic Behavior Consultation (Medicaid Waiver- FIS and CL only)
___ Assistive Technology Assessment (Medicaid Waiver or Private Pay)
___ Individual and Family/Caregiver Training (Medicaid Waiver- FIS only)
___ Behavior Consultation (Private Pay)
___ IEP Advocacy and Consultation (Private Pay)

If this is a request for an AT Assessment, please describe the products and services being explored and how they relate to the ISP:

Individual Being Referred for Services

First Name:
Last Name:
Date of Birth:
Phone Number:
Address:
Medicaid Number:
Individual Support Plan Year:

Client Preferences for Considerations

Please indicate here client preferences for Old Town ABA's consideration when matching with a consultant. *Examples*: Languages other than English, modality of services, time of day and days of the week for appointments/availability, etc.

Primary Diagnosis:
Secondary Diagnosis:
Other Diagnoses:

Guardian:
Relationship:
Guardian Mobile Phone:
Guardian Email:
Guardian Address:

Other treatments and services currently being utilized ***(Select All)***

☐ Personal Assistance	☐ Respite	☐ Speech/Language Therapy	☐ Occupational Therapy	☐ Physical Therapy
☐ Outpatient Counseling	☐ Group Counseling	☐ Companion Services	☐ REACH	☐ Group Day Services
☐ Group Supported Employment	☐ IFCT	☐ Individual Supported Employment	☐ In-Home Support Services	☐ Residential Services
☐ Other:				

History of Previous Behavior Services

Describe any/all behavioral services the individual has received or is actively receiving (ABA therapy, TC, etc.):

Individual Behavioral Profile

Primary Behavioral Concerns:
Describe how they are engaging in the following
Making Requests:

Waiting:
Accepting Removals, Transitioning, Sharing, and Taking Turns:
Completing Consecutive, Brief Known Tasks:
Accepting No:
Completing Daily Living Skills:
Following Directions:
Tolerating Health and Safety Measures (medication, procedures, etc.):

Current Services & Contact Information

Service: Phone: Organization Name: Address: Contact Email & Phone:
Service: Phone: Organization Name: Address: Contact Email & Phone:
Service: Phone: Organization Name: Address: Contact Email & Phone:

Current Medications

Name	Purpose	Dosage
May attach medication sheet if exceeds space available.		

Current Schedule

	Monday	Tues	Wed	Thurs	Friday	Sat	Sunday
Morning (8:00 a.m. - 12:00 p.m.)							
Afternoon (12:00 p.m. - 4:00 p.m.)							
Evening (4:00 p.m. - 8:00 p.m.)							

*Provide indication of schedule/availability for all parties involved within services if different from the client/above (i.e., caregivers, providers, etc.)

Please attach copies of the ISP, school evaluations of IEPs, VIDES, SIS, Medication List, Psychological Reports, Physician Reports, Previous Behavior Support Plans, Incident Reports, etc.

OLD TOWN ABA

Thank you for choosing Old Town ABA!