

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**

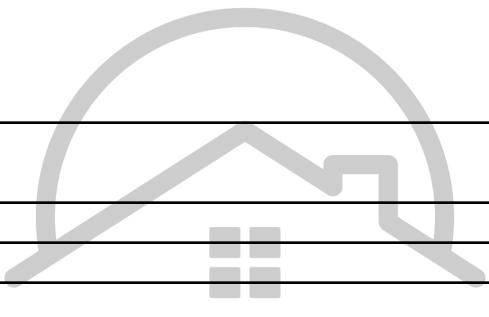
First Name:
Last Name:
Date of Birth:
Phone Number:
Address:
Medicaid Number:
Individual Support Plan Year:

**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:

The logo for Old Town ABA features a stylized, abstract design in the center. It consists of a large, semi-circular shape at the top, a jagged line that dips down and then rises, and a small square grid below it.

**OLD TOWN ABA**

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

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

<input type="checkbox"/> Personal Assistance	<input type="checkbox"/> Respite	<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Outpatient Counseling	<input type="checkbox"/> Group Counseling	<input type="checkbox"/> Companion Services	<input type="checkbox"/> REACH	<input type="checkbox"/> Group Day Services
<input type="checkbox"/> Group Supported Employment	<input type="checkbox"/> IFCT	<input type="checkbox"/> Individual Supported Employment	<input type="checkbox"/> In-Home Support Services	<input type="checkbox"/> Residential Services
<input type="checkbox"/> 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.**



*Thank you for choosing Old Town ABA!*