Patient Referral Form *Required Fields

☐ ABA Therapy ☐ Onsite Autism Diagnostic Services (Buffalo NY)

Patient Information

Last* | First* | Middle

Address* | Apartment Number

City* | State* | Zip*

Date of Birth* (/ /) | Diagnosis* | Gender* ☐ Male ☐ Female

Primary Guardian Information*

Last* | First* | Middle

Address* | Apartment Number | City*

State* | Zip* | Email Address*

Relationship to Client* | Home Phone Number* ( ) | Cell Phone Number ( )

Date of Birth (/ /) | Employer | Social Security Number (- -)

Parent/Guardian's Preferred Language

Insurance Information

Primary Insurance Company* | Policy ID #* | Group #*

Primary Insurance Phone Number* ( ) | Policyholder Name* | Relationship to Client*

Are You Receiving State-Funded Insurance? (Yes No) | If Yes, State Plan & ID Number

Behavior Concerns

Please list current behavior concerns for the patient: (e.g., language/communication, aggression, academic/cognitive skills, community participation, appropriate play/leisure skills, etc).

Referring Physician Information

Physician Name | Phone Number ( ) | Fax Number ( )

Address*

How did you hear about us? (Check all that apply)

☐ Facebook ☐ Google ☐ Insurance Provider ☐ Event ☐ Regional Center ☐ School ☐ Physician ☐ Website ☐ Other

Fax completed form to (888) 507-3996 or email to intake@autismlearningpartners.com
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