Belay On
Autism Services

Referral Form

Please included a copy of the diagnostic report and prescription along with referral script, if possible. After your referral script, a free clinical consultation will be provided by our Board Certified Behavior Analyst to help the family determine if ABA is the appropriate treatment for their child.

469-423-5658 | belayonautismservices.com | info@belayonautismservices.com

Referring Provider Information

Provider Name: _____

Phone: _____ Email: _____

Referring Provider is the: ☐ Diagnosing Provider ☐ GP / PCP / Pediatrician ☐ Other

Caregiver / Child Information

Child Name: _____ Date of Birth: _____

Social Security # (optional) _____ Autism Diagnosis? ☐ Yes ☐ No

Caregiver Name: _____ Phone: _____

Address: _____

Insurance Provider: _____ Policy #: _____

Primary Care Physician: _____ Phone: _____

Is the child currently receiving ABA services or have they in the past? ☐ Yes, Currently ☐ Yes, In The Past ☐ Never

Location: _____ Start Date: _____

Approximately how many hours/ week? _____ Duration of Services: _____

List any prenatal and perinatal events, developmental history (social, physical, psychological, intellectual, and academic) or family history of ASD:

Are there any spiritual, cultural, or legal variables that may impact treatment? ☐ Yes ☐ No

If so, please list those: _____

Are you currently utilizing any community resources (support groups, social services, school based services, other social supports) or have you in the past? ☐ Yes ☐ No

If so, please list those: _____

List any current medical conditions including allergies(food or drug), and details (dates and provider of treatment, interventions, responses/reactions):

Diagnosing / Screening Information

Primary Diagnosis Code: _____ Date of Diagnosis or Screening : _____

Severity Level: (if known)
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Screening Tool Used:
- ☐ M-CHAT
- ☐ ASQ
- ☐ CARS-2
- ☐ Other _____

Diagnosing Tool Used: (This is required for insurance purposes)
- ☐ ADOS-2
- ☐ ADI-R
- ☐ GARS-3
- ☐ Other _____

Key Components of Diagnostic Evaluation

- ☐ Standard caregiver or clinician - rated screening instrument based on DSM-V
- ☐ Standard psychiatric assessment
- ☐ Interviews with child and family
- ☐ Assessment of the caregiver's knowledge of autism spectrum disorder, coping skills, and available resources and supports
- ☐ Review of past records
- ☐ Attention to areas of relevant diagnosis
- ☐ Attention to possible comorbid diagnosis
- ☐ Observation of board areas of DSM-V criteria (social interaction and restricted, repetitive behaviors)
- ☐ Medical assessment (physical, hearing screening, etc.)
- ☐ Psychological assessment (cognitive and adaptive skills, standardized intelligence tests)
- ☐ Communication assessment (receptive/expressive language, vocabulary)
- ☐ If receiving any additional services assessments from provider

*For reference only

Additional Notes: