



This form is to be completed and submitted to Prestige ABA Therapy Services, Inc. by only developmental pediatricians and other providers (physicians, physician’s assistants, psychologists and nurse practitioners) who have experience and training in the diagnosis of an Autism Spectrum Disorder. (Forms received from any other type of provider cannot be processed.) Individuals must have a medical diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder that has been substantiated with a comprehensive assessment.

***Please Note:** We offer In Clinic Services at our East Providence location for children ages 2-10 for up to 32 hours per week Monday-Friday.

Patient Demographic Information

Child’s Name: _____
Child’s DOB (mm/dd/yyyy): ____/____/____
Parent/Guardian Full Name: _____
Contact Phone number: ____-____-____
Contact Email: _____
Home Address: _____

Patient Insurance Information

Primary Insurance Name: _____
Member ID: _____
Subscriber’s Name: _____
Subscriber’s DOB (mm/dd/yyyy): ____/____/____

Secondary Insurance Name: _____
Member ID: _____
Subscriber’s Name: _____
Subscriber’s DOB (mm/dd/yyyy): ____/____/____

Other Insurance: _____

Referring Doctor Information

Doctor’s Full Name: _____
NPI: _____
Practice Name: _____
Practice Address: _____
Practice Phone: ____-____-____
Practice Fax: _____
Practice Email: _____
Contact Name: _____

Clinical Information

Client's Diagnosis Code(e.g. F84.0): _____

Client's Diagnosis Code (e.g. Autistic Disorder): _____

Date of Diagnosis (mm/dd/yyyy): ____/____/____

Diagnostic Severity (per DSM-5 Diagnostic Criteria):

___ Level 1: Requiring Support

___ Level 2: Requiring Substantial Support

___ Level 3: Requiring Very Substantial Support

REASON FOR REFERRAL (*Check all that apply; describe **WHAT** problem behavior looks like & **HOW OFTEN** it occurs)

- Physical aggression/describe
- Verbal aggression/describe
- Property destruction/describe
- Self-injury/describe
- Elope/Dangerous behavior/describe
- Communication Needs:
- Verbal:
- Pre-Verbal:
- Non-Verbal:

Other/describe:

Where does problem behavior occur? ___home ___school ___community
___therapy/medical appointments

Physician's Signature: _____

Print Name: _____

Date: ____/____/____

By signing above, I am ordering ABA services be performed by Prestige ABA Therapy Services Inc.. Please fax or email this order for ABA Assessment to: **(401)-210-1850** or **intake@prestigeabatherapy.net**

Prestige ABA Therapy Services, Inc.
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