Acuity Behavior Solutions

Applied Behavior Analysis Referral Form

Phone: (714) 696-2862 Fax: (714) 242-9308

Website: www.acuitybehaviorsolutions.com

Email: Info@acuitybehaviorsolutions.com

Child and Family Information:

Child Full Name: ______________________________________ DOB: ____/____/_____

Parent or Guardian Name: ____

Home Phone: ________________________ Cell Phone: ________________________

Email: _______________________________ Best Time for Contact: _______________

Preferred Language: ____

Insurance Company: ______________________ Member ID: ___________________

Referring Agency Information:

Referring Agency/Doctor: ____

Contact Name: ________________________________ Phone: ________________

Address:____

City/State/Zip:____

Fax:_______________________________ Email:_______________________________

Diagnosis: ____

Reason for Referral:

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I, ____________________ (caregiver name) hereby authorize the above referring agency and/or its designated employees to exchange/receive the protected information regarding the individual/patient indicated above with Acuity Behavior Solutions and/or its designated employees. I request that the information released pursuant to this authorization be used for the following purposes only: behavioral health treatment for autism/Applied Behavior Analysis. I understand that this authorization is voluntary and I have a right to receive a copy of this authorization for my records.

Signature: ____________________________________ *Date:* ________________

Our mission is to provide quality, research-based interventions to our clients and their families.