behavioral INNOVATIONS

FAST TRACK FORM

Accelerate Your Patient's Progress with A Faster Path to ABA Services

855-782-7822 210-802-4122 referrals@bi-aba.com

PRACTICE INFORMATION

Practice Name : _____

Provider Name : _____

Phone Number : _____ **E-Mail** : _____

Provider Type : ☐ DIAGNOSING PROVIDER ☐ GP/PCP/PEDIATRICIAN ☐ OTHER

PARENT / CHILD INFORMATION

Child Name : _____ **Date of Birth** : _____

Guardian / Parent Name : _____

Phone Number : _____ **E-Mail** : _____

Autism Diagnosis : ☐ YES ☐ NO

DIAGNOSING / SCREENING INFORMATION

Primary Diagosis Code : _____

Date of Diagnosis / Screening : _____

Severity Level : ☐ 1 ☐ 2 ☐ 3

Screening Tool Used : ☐ M-CHAT ☐ ASQ ☐ OTHER Please Specify : _____

Diagnostic Tool Used : ☐ ADOS-2 ☐ ADI-R ☐ GARS-3 ☐ CARS-2
(Required for insurance purposes)

☐ OTHER Please Specify : _____

If possible, please include a copy of the diagnostic report and prescription along with referal script. After we receive your referral script, we will provide a free clinical consult from our Board Certified Behavior Analyst to help the family determine if ABA is the appropriate treatment for their child.