Patient Referral Form *Required Fields

☐ Autism Evaluation/ Diagnosis ☐ ABA Therapy

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*

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

Social Security Number* Date of Birth*

Parent/Guardian's Preferred Language* Parent/Guardian's Email Address*

Insurance Information*

Primary Insurance Company* Policy ID #* Group #*

( )

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

Secondary Insurance Company (if applicable) | Policy ID # | Group #

( )

Secondary Insurance Phone Number | Policyholder Name | Relationship to Client

Are You Receiving State-Funded Assistance? (Yes/) *
No (i.e. Katie Beckett)

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 Provider Information*

Provider Name* | NPI #* | Facility Name*

Address*

Phone Number* | Fax Number* | Email Address*

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

☐ Facebook Google Insurance Provider Event School Physician Website Other

Fax completed form to (888) 571-2475 or email to intake@atlantaautismcenter.com
(E-Referrals) Direct Address: george.katsitadze@aacecw.eclinicaldirectplus.com
www.atlantaautismcenter.com
Phone: (833) 628-8476