Foothills Behavior Specialists

Referral Form

Covington, WA | Fax: (425) 310-6602 | Email: e.laina@foothillsbehavior.com | www.foothillsbehavior.com

Patient Information

Child's Name: _____ DOB: _____ Age: _____

Parent/Guardian: _____ Phone: _____ Email: _____

Home Address: _____

_____

Referring Provider

Provider/Practice: _____ Contact Person: _____

Phone: _____ Fax: _____

Address: _____

_____

Insurance Information

Primary Insurance: _____ Member ID: _____

Group #: _____ Secondary Insurance (if any): _____

Reason for Referral (check all that apply)

■ Autism Spectrum Disorder (ASD)

■ Behavioral Concerns

■ Social/Communication Delays

■ Daily Living Skills

■ Other:

_____

Requested Services

■ Comprehensive ABA Evaluation

■ 1:1 ABA Therapy

■ Parent/Caregiver Training

■ Behavior Support Plan Development

Clinical Notes / Specific Concerns

_____

_____

_____

Authorization

Referring Provider Signature: _____ Date: _____

Fax completed referral to (425) 310-6602 • Email: e.laina@foothillsbehavior.com