



REFERRAL FORM

Please complete the details below to refer to our office.

Patient name: _____ DOB: ____/____/____

- This referral is for:**
- | | |
|--|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Psychological Testing
<i>(Not available in Winston-Salem)</i> | <input type="checkbox"/> ABA Therapy
<i>(Available in CLT/Huntersville/Mooresville/Winston)</i> |

****When referring a patient for ABA evaluation/therapy, please submit the following documentation in addition to your referral. Please note, without this documentation the child will not be able to complete the ABA evaluation.**

- **Service Order** (from PhD, PsyD, MD, DO) for RBBHT or ABA
- **Autism Diagnosis and Supplemental Documentation**
 - i.e., ADIR, ADOS, CARS, GARS
- **For Cardinal patients ONLY**, a Cardinal Prior Approval Form is required to be completed by the referring physician.

Reason for referral (Check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> <i>Fine motor concerns</i> | <input type="checkbox"/> <i>Gross motor concerns</i> | <input type="checkbox"/> <i>Sensory Processing</i> |
| <input type="checkbox"/> <i>Behavior concerns</i> | <input type="checkbox"/> <i>Coordination</i> | <input type="checkbox"/> <i>Developmental Delay</i> |
| <input type="checkbox"/> <i>Speech Delay</i> | <input type="checkbox"/> <i>Other:</i> _____ | |

Diagnosis: _____

CONTACT INFO

Caregiver's name: _____

Phone number(s): _____

Address: _____

Insurance: _____

Referred by: _____ at _____

Please fax to Pediatric Advanced Therapy at 704-799-6825.

Thank you for your continued referrals!

PH: 704-799-6824 • FAX: 704-799-6825

Charlotte – Concord – Huntersville – Matthews – Mooresville – Salisbury – Winston-Salem