REFERRAL FORM

Please complete the details below to refer to our office.

Patient name: _____ DOB: ____/_____/_____

This referral is for: ☐ ***Physical Therapy*** ☐ ***Occupational Therapy***
☐ ***Speech Therapy*** ☐ ***Counseling***
☐ ***Psychological Testing*** ***(Matthews only)*** ☐ ***ABA Therapy*** ***(All locations except Matthews)***

*****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):

☐ *Fine motor concerns* ☐ *Gross motor concerns* ☐ *Sensory Processing*
☐ *Behavior concerns* ☐ *Coordination* ☐ *Developmental Delay*
☐ *Speech Delay* ☐ *Other:* _____

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