REFERRAL FORM

Name of Referring Physician _____ Date _____

Address _____

Phone _____ Diagnosis _____

**Please answer the questions below.

Diagnosis: ☐ Autism Spectrum Disorder (ASD) ☐ Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS) ☐ Other

Requested Therapy ☐ Assessment for Applied Behavior Analysis Therapy ☐ Behavior Analysis Therapy

☐ Social Skills Therapy

PATIENT INFORMATION

Name: _____

Address: _____

Date of Birth: _____

Phone Number: _____

Please have patient forward the following to rrtsdallas2@gmail.com or to fax number(972) 637-9842. To initiate services please include the following:

- This referral form
- Healthcare Insurance card (front & back copy)

Prescription for ABA Therapy

Physician Signature _____ Date _____

511 N. Akard St. Dallas, Tx 75226 Office: (214) 382-0560 Fax: (972) 637-9842