S.T.A.R.S. Consulting, LLC

Specialized Therapies for Autism and Related Services

Applied Behavior Analysis Referral Form

Referring Professional

Referring Agency: _____ Date of Referral: _____

Contact: _____ Phone: _____

Is the client/parent aware of this referral? ☐Yes ☐No

Is this referral urgent? ☐ Yes ☐ No If yes, please tell us why with details.

_____

_____

_____

Name: _____

Practice: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Patient Information

Name: _____
First Middle Last

Birth Date: _____/_____/_____ Age: _____ Gender: Male Female

Parent's Names: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Phone Number 1: _____ Who's Number? _____

May we leave a message? ☐ Yes ☐ No

Phone Number 2: _____ Who's Number? _____

May we leave a message? ☐ Yes ☐ No

E-Mail: _____

May we email? ☐ Yes ☐ No *Note Email is not considered to be a confidential measure of communication

Diagnosis: _____ Date of Diagnosis: _____

Has your child received behavioral services in the past? _____

Date of Previous Services: _____Previous provider: _____

May we contact this provider to receive data or documentation on targeted behaviors? ☐ Yes ☐ No

Behavior Problems or Skill Development Concerns:_____

_____

_____

_____

Insurance Information

Medicaid? YES NO Number: _____

Is Medicaid your PRIMARY SECONDARY

Primary Medical Insurance Name:_____

Subscriber's Name_____

Dependent Name_____DOB:_____

Member ID: _____ Group/Subgroup: _____

Authorization Phone Number (On back of the Card)_____

Primary Medical Insurance Name:_____

Subscriber's Name_____

Dependent Name_____DOB:_____

Member ID: _____ Group/Subgroup: _____

Authorization Phone Number (On back of the Card)_____

I authorize STARS to contact and receive authorization of and payment for medical health insurance provided above for services rendered.

I understand I am responsible for keeping STARS informed of changes in insurance and will be responsible for services rendered that are not covered by insurance due to failure to provide notice of change.

Parent's Signature: _____ Date:_____

Don't forget:

☐ Copy of the clinical Diagnostic Evaluation

☐ Copy of the front and back of all insurance cards

☐ Signed Medical Information Release for Referring Provider to STARS Consulting

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HIPPA General Medical Release Form

I hearby authorize the disclosure of the following medical records and give my express permission for ongoing consultation with the person's named below.

Office/Person releasing information: _____

Name of person authorizing release of information: _____

Patient's Name:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Contact Number: _____

To release my information to:

Name: _STARS Consulting_____ Relationship: __ABA Providers__

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization applies to the following:

[ ] Diagnosis

[ ] Treatment Plans

[ ] Ongoing Consultation

[ ] Immunizations

[ ] Other Health Conditions that may affect treatment

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____