Office (888) 880-9270 Fax (954) 342-0273 ButterflyEffects.com

ButterflyEffects™
Transforming lives through ABA therapy

Client Intake Form for ABA Therapy

Thank you for referring your patient to Butterfly Effects for ABA Therapy. Please fill out the following information and submit via fax or email. If possible, please also attach the Supporting Documentation listed below. We will call you to confirm receipt of this referral.

Fax: (954) 342-0273 or Email: Clientservicesdept@butterflyeffects.com

Date of referral: _____

Name of physician submitting referral: _____

Clinic/practice name: _____

Clinic phone: _____ Clinic fax: _____

Clinic contact: _____

Patient Information

Patient Name: _____ Patient DOB: _____

Gender: ☐ Male ☐ Female

Parent/Guardian Name(s): _____

Parent/Guardian Contact Info

Email address: _____

Home address: _____

Home phone number: _____ Cell phone number: _____

Is patient aware of the referral: ☐ Yes ☐ No

Insurance Information

Primary insurance: _____ Policy holder: _____

Supporting Documentation Checklist

☐ The patient's comprehensive diagnostic evaluation (if available) that includes standardized testing and scores signed by a physician (MD/DO) or a clinical psychologist.

☐ A referral for therapy that is signed by a physician and includes a diagnosis code for Autism Spectrum Disorders (F84.0).

☐ A copy of the patient's annual physical that was completed within the past year. (Required for Massachusetts only)

☐ **All information is contained on the submitted documents**