

# Autism Diagnosis / ABA Therapy Referral Form



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## **Referral Information:**

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_

Caregiver's: Phone \_\_\_\_\_ Email \_\_\_\_\_

Primary Language: \_\_\_\_\_

Physician: \_\_\_\_\_ Facility/Clinic: \_\_\_\_\_

Referral Coordinator/Office Manager: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## **Reason for Referral:**

**ABA Therapy** (2 - 12 years old)

If available, please send official autism diagnosis report with this referral page.

**Autism Developmental Diagnosis** (18 months - 5 years old)

*For PDF form fillables visit [www.ABSKids.com/Resources/](http://www.ABSKids.com/Resources/)*