

## Applied Behavior Analysis Service Order / Referral Form

Please fax the completed referral form to (919) 467-6777 and attention "KBH Intake Team". If you have any questions, feel free to contact our Intake Team directly at intake@kindbh.com.

Patient Information	
Patient's Full Name	
Patient's Date of Birth (mm/dd/yyyyy)	
Patient's Street Address	
City/ State/ Zip	
Patient's Phone Number	
Patient's E-Mail Address	
Does Patient have an F84.0 ASD Diagnosis?	0 Yes 0 No
Date of Diagnosis (mm/dd/yyyy)	
Diagnostic Severity Level (Per DSM-5 Diagnostic Criteria)	<ul> <li>Level 1: Requiring Support</li> <li>Level 2: Requiring Substantial Support</li> <li>Level 3: Requiring Very Substantial Support</li> </ul>
Referring / Ordering Provider Information	
Referring/Ordering Provider Name	
Name of Practice	
Provider's Phone Number	
Provider's Fax Number (optional)	
Practice Street Address	
City/ State/ Zip	
Provider's NPI	
Referring/Ordering Provider Signature and Credentials:	

according to their scope of practice shall complete and sign a service order. Each service order must be signed and dated by the authorizing professional and







must indicate the date on which the service was ordered.'





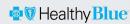














\*\*\* Per the Medicaid Clinical Policy (CCP-BF): "A Licensed Medical Doctor (MD), Licensed Doctor of Osteopathic Medicine (DO), or Licensed Psychologist

















