Carolina Therapeutics, PLLC

ABA THERAPY PRESCRIPTION & REFERRAL FORM

Patient's Name: _____ Date of Birth: _____

Contact Name: _____ Phone No.: _____

ABA Therapy Referral Questions

1. Has the patient been diagnosed with **Autistic Disorder**? (ICD-10 Code **F84.0**) ☐[Yes] ☐[No]
2. Is ABA Therapy a medical necessity for this patient? ☐[Yes] ☐[No]
3. Do you recommend any other therapy services for this patient at this time? ☐[ST] ☐[PT] ☐[OT]

Other: (please list any other specific ICD-10 Code relevant to this patient and provide a description of the subject condition)

_____
_____
_____
_____
_____

Additional Physician Comments Relevant to this Patient

_____
_____
_____
_____
_____

ABA Therapy Service(s) Requested:

☐Evaluation / Treatment Evaluation Only☐

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ NPI#: _____

When signed by a physician, this form acts as a prescription for ABA therapy services.
Please fax this form along with any additional relevant medical information to 980-938-6088.

Professional Therapy Services Brought to Your Doorstep!
www.carolinatherapeutics.com • info@carolinatherapeutics.com
P.O. Box 38118, Charlotte, NC 28278-8932 • Tel 704.654.8599 • Fax 980.938.6088