Carolina Therapeutics

ABA THERAPY PRESCRIPTION & REFERRAL FORM

Patient Name: _____ DOB: _____

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. Additional therapy services recommended for this patient at this time:

☐ Speech therapy ☐ Occupational therapy

☐ Physical therapy ☐ None

Additional Diagnoses

ICD-10 Code		*Description*
_____	-	_____
_____	-	_____
_____	-	_____
_____	-	_____

Professional Therapy When & Where You Need Us!
www.carolinatherapeutics.com · info@carolinatherapeutics.com
Tel 704.654.8599 · Fax 980.938.6088

Carolina Therapeutics

Additional Physician Comments Relevant to this Patient

_____

_____

_____

_____

_____

Physician Signature & Referral

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.

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