Therapeutic Alliance

Referral Sheet

Date_____ **WIFI Access**_____

Client Name _____**DOB**_____

Guardian Name _____

Phone Number_____ **Guardian Email**_____

Referral Source_____**Case Worker**_____

Referral Source e-mail and phone_____

Primary Insurance and Number _____

Secondary Insurance and Number _____

Home Address _____

School _____**Grade**_____**Spec Ed**_____

Primary Physician _____

Specialist_____

Medications _____ **Allergies**_____

Diagnosis_____

Behaviors/ Concerns _____

_____

Services Needed: ABS (ABA or EPSDT), IIH, MHSS, FAPT
Child's availability for treatment: Days, Evenings, After School **Fax Referral to: 1-866-499-8840**