Physician Referral for ABA Therapy for Autism Spectrum Disorders

Please fax completed form to: (706) 243-6497 or e-mail to: info@milestonesga.com

Patient Name:_____
Patient Date of Birth:_____
Patient Diagnosis (ICD-10 code)_____
Parent/Guardian Name:_____
Patient Phone:_____
Physician Name:_____
Practice Name & Address:
_____
_____
Practice Phone:_____**Fax:**_____
Service(s) Required (Please heck all that apply):

Applied Behavior Analysis (ABA)

- Behavior Identification Assessment
- Adaptive Behavior Treatment
- Family Adaptive Behavior Treatment

Speech Language Services

- Evaluation and Treatment of Articulation (speech sounds)
- Evaluation and Treatment of Language (expressive and/or receptive)
- Evaluation and Treatment of Cognitive-Communication
- Evaluation and Treatment of Pragmatics (social language)

Any additional
comments:_____

I hereby certify the medical necessity of the services listed above.

X_____ _____ _____
Physician Signature **Date** **Physician NPI#**