Livingston & Cleveland
(936) 441-2200 MAIN
(936) 570-9088 FAX
www.InclusionABA.com

ABA Therapy Order

Patient Name:______________________________ **Date of Birth:** _________________

Primary Language: ☐ **ENGLISH** ☐ **SPANISH** **OTHER:**___________________

Caregiver Name:______________________________ **Phone:** ___________________

Primary Insurance:_______________________ **ID#:** _____________________

Secondary Insurance:______________________ **ID#:** ______________________

Patient Diagnosis: **Autism F84.0**____

DSM-5 Autism Severity Level: ☐ **Level 1** ☐ **Level 2** ☐ **Level 3**

Precautions:____

Given the Autism diagnosis, it is recommended the patient receive up to 40 hours per week or as recommended by the evaluating Board Certified Behavior Analyst. I certify medical necessity for evaluation & treatment.

______________________________________ ________________________
Physician Signature **Date**

______________________________________ ________________________
Physician Name (Printed) **NPI**

____
Phone

Please include patient demographics and autism diagnostic evaluation.