Collaborative SOLUTIONS
By Dr. Nikki Keefer & Assoc., Inc.
Your ABA Experts

3516 Wild Eagle Run Oviedo, FL 32766 407-489-2121 407-719-2101 fax (407) 542-4806 Collaborative-Solutions.org

CLIENT REFERRAL FORM

Date _____ **Date Received _____**
(Office Use)

Client Full Legal Name (Last, First, MI): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____

Diagnosis: _____

Other Relevant Conditions:_____

Mother / Legal Guardian: _____

Relationship: (please check)

Biological _____ Adoptive_____ Step _____ Foster _____

Address: _____

Home Phone ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

Email: _____

Occupation: _____ Title: _____

Highest level of education (please circle) High School College Graduate School
9, 10, 11, 12 1, 2, 3, 4

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Collaborative SOLUTIONS
By Dr. Nikki Keefer & Assoc., Inc.
Your ABA Experts

Father/ Legal Guardian: _____

Relationship: (please check)

Biological _____ Adoptive_____ Step _____ Foster _____

Address: _____

Home Phone ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

Email: _____

Occupation: _____ Title: _____

Highest level of education (please circle) High School College Graduate School
9, 10, 11, 12 1, 2, 3, 4

Employer: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

Parents' Marital Status: Married _____ Separated _____ Divorced _____ Single_____ Widowed _____

Child lives with (*check all that apply*) Father _____ Mother _____ other (specify) _____

CLIENT'S SIBLINGS

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

CLIENT'S PRIMARY CARE PHYSICIAN

Name: _____ Clinic/Company practice: _____

Collaborative SOLUTIONS
By Dr. Nikki Keefer & Assoc., Inc.
Your ABA Experts

Address: _____

Phone: ( ) _____ Fax: ( ) _____

What agency or individual referred you here for services?

Name: _____ Phone: _____
Address: _____
_____

Program of Interest
Please consider my child for placement in the following programs:

_____Home-Based Services (patient could benefit from ABA (applied behavior analysis) therapy in the Home and community)

_____Social Skills (patient could benefit from brief regular facilitated social interaction with peers in the community)

_____Early Intervention (my child is between 2-6 and needs intensive behavior therapy)

Preferred Schedule: ____ days a week ____ Other: (please describe): _____

_____ School-Based Services (patient could benefit from ABA (applied behavior analysis) therapy in the school, pre-school, after-care program (Please indicate which particular setting)

Services:

_____ Consultation
_____ IEP planning, development, process
_____ Staff training/parent training
_____ Mental Health Therapy/Counseling
_____Other (please explain): _____

Insurance and/or Funding Information	
List which insurance plan you have:	
NOTE: client will need to call and request they send a referral to Collaborative Solutions by Dr. Nikki Keefer & Assoc. Inc.	
Name of Insurance Company	Plan Name (i.e., PPO, self-funded, etc.)
ID #:	Group #:
Phone number for customer service for providers:	Plan renewal date:
Copay:	Has your deductible been met? Y or N
Card Holder's or Primary Insured's Information	

Name:	
Relationship to client:	
__Male __Female	Date of Birth
Social Security Number:	Name of Employer:
Medicaid Information	
Name of Medicaid program:	Child's Medicaid number:
Y N We have applied for a waiver (circle which)	
Y N We are on a waiting list for a waiver (circle which)	

THERAPY INFORMATION

Please list client's <u>current</u> therapies and/or other treatment professionals:

Date started: _____

Type of services: _____

Service provider: _____

Contact Information: _____

Date started: _____

Type of services: _____

Service provider: _____

Contact Information: _____

Date started: _____

Type of services: _____

Service provider: _____

Contact Information: _____

Collaborative SOLUTIONS
By Dr. Nikki Keefer & Assoc., Inc.
Your ABA Experts

Date started: _____

Type of services: _____

Service provider: _____

Contact Information: _____

Complete this section if your child attends a school, center, preschool, etc.
Current Facility and Address:
Grade Level if school:
_____ Date Enrolled:
Contact Information:
Y N Child has an IEP (If child has an IEP, a recent copy should be submitted with this packet or as soon as possible) Y N Child has IFSP (If child has an IFSP, a recent copy should be submitted with this packet or as soon as possible)

EDUCATIONAL PROFILE

Please indicate schools attended in chronological order.

School Name and Level	Date Attended

Has your child ever received special education services? Please explain

_____

_____

_____

_____

Describe any current school programs.

_____

_____

_____

_____

_____

Has your child ever received any developmental evaluation or testing in the past?

_____

_____

_____

_____

_____

_____