



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

6914 Aloma Ave Winter Park, FL 32792

office 407-489-2121 fax 407-951-7075

email: inquiries@Collaborative-Solutions.org website: www.collaborative-solutions.org

Date _____

Date Received _____ (Office Use)

CLIENT REFERRAL FORM

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: _____



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: _____



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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:

- _____ In-Home/Community ABA Services
- _____ Social Skills Peer Group
- _____ Early Intervention (my child is between 2-6 and needs intensive behavior therapy)
- _____ School-Based Services (including daycare, pre-k, etc)
- _____ Parent Training Individual
- _____ Parent Training Group
- _____ In-Clinic ABA Services (Winter Park Location)

Services:

- ___ Consultation
- ___ IEP planning, development, process
- ___ Staff training/parent training
- ___ Mental Health Therapy/Counseling
- ___ 1:1 ABA Therapy
- ___ Group ABA Therapy
- ___ Other (please explain): _____

Availability:

Please list your availability for services:

Sunday _____

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____



Do you have a copy of your child's current ASD diagnoses (if applicable) with a comprehensive evaluation? (Y or N)_____

Diagnosis Date:_____

Diagnosing Physician's Name, Credentials, address, and phone number:

Currently we accept the following Insurance plans:

- | | |
|---------------------------------|----------------------|
| Aetna | CDC+ |
| UMR | United Healthcare |
| Blue Cross Blue Shield | AdventHealth |
| Florida Hospital Health Systems | Orlando Health |
| Disney Cast Member | Rosen Hotel Employee |
| Cigna | USPS Employee |

If your plan is not listed please call the office to verify that we are an in-network provider.

Insurance and/or Funding Information	
List which insurance plan you have:	
<i>NOTE: Client will need to call insurance and verify ABA benefits including requirements for qualifying ABA services.</i>	
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:	
<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth	Name of Employer:
Social Security Number:	
Address:	
Phone:	

THERAPY INFORMATION

Please list client's current 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: _____



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.



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

Describe the reason(s) for seeking ABA services at this time:

Please return completed packet to:

email: inquiries@collaborative-solutions.org
fax: 407-951-7075
mail: 6914 Aloma Ave. Winter Park, FL 32792

If utilizing insurance please include a FRONT and BACK copy/picture of your insurance cards, and a copy of your child's ASD diagnosis with full comprehensive evaluation.