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: _____

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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: _____

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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)

_____In-Clinic ABA Services (Oviedo 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_____

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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:	
NOTE: Client will need to call insurance and verify ABA benefits including requirements for qualifying ABA services.	
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	Name of Employer:
Social Security Number:	
Address:	
Phone:	

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: _____

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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?

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.