PEDIATRIC SPECIALTY CLINICS

easterseals Florida

FAX to: 386-258-7677

Physician Referral for (Child's Name) _____ (M) ☐ (F) ☐ DOB _____

Parent/Guardian _____ Phone _____ Relationship _____

Address _____ City _____ St ____ Zip _____

Primary Insurance _____ Policy # _____ Group # _____

Subscriber Name _____ Subscriber DOB _____

Email _____

☐ **Autism Diagnostic and Functional Assessment**
May include: ADOS-2, EarliPoint, Occupational Therapy, Physical Therapy, Speech Therapy, and Audiology Evaluations

☐ **Pediatric Therapy Evaluation and Treatment**
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech/Language Therapy

☐ **Applied Behavior Analysis Therapy (ABA) – *Diagnosis required***

☐ **Mental Health Counseling – (*treatment 6yrs and older)***

Diagnosis Code: _____ (Z codes are not Permitted)

(F84.0 can only be used for children who have already been diagnosed with Autism)

***The referral for evaluation expires 1 year from the date signed.**

Physician Name _____ Signature _____

Physician Address _____

Physician NPI# _____ Referral Date _____

Email _____ Phone _____ Fax _____

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