



Referral, Payment and Permission Form

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| Date of Referral: _____ | |
| School/District or Agency Information | |
| Name of person being referred: | Date of Birth: |
| | Grade (if applicable): |
| School District/School Name and Address (if applicable) | Agency Name and Address (if applicable) |
| Primary Contact Person: | Primary Contact Email Address: |
| Position/Title of Primary Contact Person: | |
| Parent/Guardian Information | |
| Parent(s) Names | Phone Numbers Home: Work: Cell: |
| Address: | |
| Email Address: | |
| Diagnosis Information | |
| Does the individual have a diagnosis and if so what is it and when was it received? <i>Please include copies of the current educational or vocational plan and the most recent evaluation.</i> | |

Consultation Referral

If referring for a consultation please identify at least 3 focus areas

- | | | |
|---|--|---|
| <input type="checkbox"/> Program Planning | <input type="checkbox"/> Play/Leisure Skills | <input type="checkbox"/> Educational Strategies |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Behavior | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> IEP Development | <input type="checkbox"/> Parent Training |

Please provide a list of all team members and their email addresses. Place an asterisk (*) by the primary contact person. You can add additional pages if necessary.

| Name | Email Address |
|------|---------------|
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Permission

I give permission for information to be exchanged regarding my child _____, the requesting district/agency _____ and Autism Behavioral Consulting, LLC. This information may include verbal exchange of information, written reports, on-site observation/training and consultation from Autism Behavioral Consulting. I can revoke this consent at any time. I also give permission for ABC to exchange any form of information about my child with the following people or agencies (name, address and phone number):

Parent/Guardian Signature: _____

If the individual being referred is over 18 years of age and is his or her own guardian then they must sign this form below and complete the release of information information in the next box.

If the individual being referred is over 18 but is not their own guardian please provide proof of guardianship when submitting this form.

Signature: _____

I give permission for information to be exchanged about me, _____, and Autism Behavioral Consulting, LLC. This information may include verbal exchange of information, written reports, on-site observation/ training and consultation from Autism Behavioral Consulting. I can revoke this consent at any time.

I also give permission for the following people or agencies which may include medical information:

Individual's Signature: _____

I have reviewed the provided information about the rates of service and agree to pay for the requested services.

Signature of the responsible party: _____

Printed name of the responsible party: _____

Date: _____

***If you have any questions please do not hesitate to contact
Brittany Schmidt at the email, phone or website below.***

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