Referral, Payment and Permission Form

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:	Primary Contact Phone Number:
Parent/Guardian Information	
Parent(s) Names:	Phone Numbers: Home: Work: Cell:
Parent(s)Address:	
Email Address:	
Diagnosis Information	
Does the individual have a diagnosis and if so what is it and when was it received? ***Please include copies of the current educational or vocational plan and the most recent evaluation.***	

1105 W. Russell St, Sioux Falls, SD 57104
605-351-1002
FAX: 605-271-3956
BrittanyABC@gmail.com
www.abc-autism.com

Consultation Referral

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

___Program Planning	____Play/Leisure Skills	____Educational Strategies
___Communication	____Behavior	____Other: _____
___Social Skills	____IEP Development	____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

Permission/Release of Information

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 (please provide each name, address and phone number):

_____

_____

_____

_____

Parent/Guardian Signature: _____

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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.

Individual's 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:

_____

_____

_____

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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