Please email all referrals to info@FatajTLC.com
Please visit us at www.FaTajTLC.com

Client Referral Form for ABA services

Name: _____ **Social Security #:** _____

Birth Date: _____ **Age:** _____ **Parents/Caregivers names:** _____

Address: _____ **County:** _____

City/State: _____ **Zip Code:** _____

Phone: _____ **Phone #2:** _____ **Email:** _____

Sex: ☐M ☐F Race: ☐White ☐Black ☐Hisp ☐Asian/Pacific ☐Hatian ☐Bi-Racial

Legal status: ☐Minor in parent/guardian custody ☐Minor in state custody ☐Competent Adult ☐Incompetent Adult

School/Employer: _____

Current Diagnoses: _____

Has the client been evaluated from another ABA agency within the past 6 mos.? ☐Yes ☐No

Funding Information:

☐Medicaid #: _____ Medicaid Type: _____

☐Other Insurance: _____ ID #: _____ Group #: _____

Insurance Phone/Address: _____

☐ **Private Pay**

Referring Agency/Individual:

Person making the referral: _____ **Name of Agency:** _____

Phone: _____ **Fax:** _____ **Email:** _____ **Date:** _____

Reason for Referral:

Please check the client's current behavioral concerns:

☐Autism Spectrum Disorder ☐Tantrums ☐Language Delayed ☐ Social skills deficits ☐ Food refusal
☐Verbal Aggression ☐Property Destruction ☐ Self-care deficits ☐Sexually Acting Out
☐Noncompliance/Defiance ☐Disruptive Behavior ☐ADHD ☐Self-Injurious Behaviors ☐Toileting Problems

Other services client currently receiving ☐Speech ☐OT ☐PT ☐ Medication Management Other

Location of Services: ☐ Home ☐ School ☐Clinic ☐ Community
Availability (please include nap time)

FaTaj Transition & Learning Center
LaTeisha Jackson, M.S., BCBA (Director)
Phone: 407-680-8957
Fax: 407-395-3487
Email: info@FatajTLC.com