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The Joshua Tree

Children's Speech, Occupational
and Physical Therapy services

ABA and Therapy Referral Form

Child's Full Name :
Date of Birth :
Parent or Caregiver Name :
Address:
Parent or Caregiver Phone:

Services Needed?

ABA Feeding Speech Occupational Physical

Location?

Marietta	Buckhead	Sharpsburg
Decatur	Roswell	Ellenwood
Tucker	Sandy Springs	Woodstock
Stone Mountain/Clarkston	Dunwoody	Brookhaven
Peachtree City	Midtown	Chamblee
Newnan	Chamblee	Jonesboro

Child has received ABA or Therapy services previously: yes no

Does child have diagnosis of autism? yes no

**Please include a copy of Rx with diagnosis

**Please include any other related reports (swallow studies, psycho educational adaptive behavioral evaluation, prior therapy evaluation)

Primary Insurance:

Plan:
Member ID:
Policyholder Name and Dob:

Secondary Insurance :

Plan:
Member ID

Primary Physician Name :

NPI number:

Office Name and Address :

Practice Fax Number :

Practice Phone Number and Email: