TidalHealth Pediatric Development & Therapy

Please complete the details below to refer to our office.

Patient name: _____ DOB: ____/ ____/ _____

This referral is for: ☐ **Speech Therapy**

☐ **Occupational Therapy**

☐ **ABA Therapy**

****When referring a patient for ABA evaluation/therapy, please submit the following documentation in addition to your referral. Please note, without this documentation the child will not be able to complete the ABA evaluation.**

- **Service order** (from PhD, PsyD, MD, DO) for RBBHT or ABA
- **Autism diagnosis and supplemental documentation**
  - i.e., ADIR, ADOS, CARS, GARS

Reason for referral (Check all that apply):

☐ Fine motor concerns ☐ Gross motor concerns ☐ Sensory processing

☐ Behavior concerns ☐ Coordination ☐ Developmental delay

☐ Speech delay ☐ Other: _____

Diagnosis: _____

Contact info

Caregiver's name: _____

Phone number(s): _____

Address: _____

Insurance: _____

Referred by: _____ at _____

TidalHealth Pediatric Development & Therapy

☐ **30265 Commerce Drive, Suite 204**
Millsboro, DE 19966
Phone: 443-978-6020
Fax: 443-998-5966

☐ **2326 Goddard Parkway**
Salisbury, MD 21801
Phone: 443-978-6022
Fax: 443-998-5966