REFERRAL FORM

Date:	Phone Intake:
Client Full Name:	DOB: Age: yrs. Sex: Male Female
Client Address:	SSN:
Preferred Contact Person:	
Parent/Guardian (if applicable): Phone:	Email:
Parent/Guardian Address (if different):	City: State: Zip:
Referred by:	Phone Number:

Innovations In Learning PC
8200 Georgia Street
Merrillville, IN 46410

Phone: (219) 791-1400
Fax: (219) 791-1422

Case Manager: _____
Agency/contact:_____

Service Requested

( ) Individual Therapy ( ) Intensive ABA Therapy
( ) Group Therapy ( ) Outpatient ABA Therapy

( ) Behavior Management ( ) Music Therapy ( ) Day Services

Medical Information

Current Diagnosis:	Physician: Phone: Psychiatrist: Phone:	Current Medications and Dosages:

Funding Source: **Insurance ( )** **Waiver ( )** **Self Pay ( )** **Other ( )**

Primary Insurance:	*Secondary Insurance:*	*Tertiary Insurance:*
Policy Holder: DOB: Policy ID #: Group ID #: Phone:	Policy Holder: DOB: Policy ID #: Group ID #: Phone:	Policy Holder: DOB: Policy ID #: Group ID #: Phone:

Additional Information (include availability)

Staff Initials: _____