Pride *Star* Center for Applied Learning

229 Stedman Street
Lowell, Massachusetts
01851

(978) 677-6952 tel. | info@pridestarcenter.com email | www.pridestarcenter.com url

PRIDE*Star* CENTER FOR APPLIED LEARNING, LLC

NEW CLIENT REFERRAL FORM

Date _____

Please fill out this form completely. Referrals will not be accepted with missing information.

REFERRAL SOURCE INFORMATION

Name of individual submitting referral

_____
First Name Last Name

Relationship to referred individual:

- ☐ parent/guardian
- ☐ referring agency: _____
- ☐ school/district: _____
- ☐ other: _____

Contact Information:

phone # ( ) -
alt. ph # ( ) -
email

IDENTIFYING INFORMATION

Client Name:

_____ | _____
First Name Last Name Date of Birth

_____
Street Address Town/City State Zip Code

Mother or Legal Guardian Information:

_____
First Name Last Name
address if different from above:

_____
Street Address Town/City State Zip Code

Father or Legal Guardian Information:

_____
First Name Last Name
address if different from above:

_____
Street Address Town/City State Zip Code

SCHOOL/PROGRAM INFORMATION

Name of School _____ Grade _____

Address: _____

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First Name	Last Name

NEW CLIENT REFERRAL FORM - continued

CLINICAL INFORMATION

Please list all current formal diagnoses and include the name of the physician who provided the diagnosis and the date:	
What are the specific concerns that you would like to see addressed? *(please attach an additional sheet if necessary)*	

If the child currently receives ABA treatment or has received ABA treatment in the past, please fill out the following section.

Please indicate source(s): *(check all that apply)*	Please describe: *(frequency, duration of treatment, type of services, reason(s) for discontinuing treatment etc…)*
☐ Individualized Education Program (IEP) *(through school district)* ☐ Outside Agency: _____ *(i.e. DDS, DMH, DCF, DESE/DDS initiative)* ☐ Private/Self-Pay ☐ other: _____	Current Provider:

INSURANCE INFORMATION

Subscriber Name: *(name of policy holder)*			
Medical Insurance Provider		Plan Name	
Policy #		Group #	
Coverage for ABA Treatment *(please contact your insurance company to obtain this information)*			

COMMITMENT TO TREATMENT

Why are you seeking services from *PrideStar Center for Applied Learning*? Please explain the level of commitment you are willing to make at home in order for your child to attain the goals set by the treatment team
(use an additional page if necessary)

Signature of person filling out form: _____