Footsteps of Change

Referral for Clinical Services

Client Information
Name: _____
Date of Birth: _____
Age: _____
Gender: [ ] Male [ ] Female
Current Diagnoses (if any): _____
_____
Current School/Day Program:
_____

Referrer Information
Name: _____
Relationship to Client: _____
Address: _____
_____
Primary Phone: _____
Secondary Phone: _____
Email: _____
Can we leave a voicemail? [ ] Yes [ ] No
Can we email you? [ ] Yes [ ] No

Payment Information
What is your preferred payment source: [ ] Insurance [ ] Private Pay
If Insurance, please provide the following information:
Insurance Company: _____ Plan Type: [ ] PPO [ ] HMO
Is this plan self-funded? [ ] Yes [ ] No Is this a federal plan? [ ] Yes [ ] No

Preferred Model of Service (Please select *one*)
[ ] In-Home Therapy [ ] Parent Training [ ] School Consultation [ ] Presentation/Training
Describe *3 top priorities* for services (e.g., toilet training, challenging behavior, etc.):
_____
_____
_____

Other Client Information
Current Medications (Please list *all*)
If unknown, please check here [ ]
_____ _____
_____ _____
_____ _____

Does the client currently receive:
If unknown, please check here [ ]
Occupational Therapy? [ ] Yes [ ] No Physical Therapy? [ ] Yes [ ] No
Speech/Language Therapy? [ ] Yes [ ] No ABA Therapy? [ ] Yes [ ] No

Does the client currently receive any alternative treatments for autism? (Check all that apply)
If unknown, please check here [ ]
[ ] GFCF Diet
[ ] Chelation
[ ] Sensory Integration Therapy
[ ] Hypobaric Chamber Therapy
[ ] Auditory Integration Therapy
[ ] B12 Shots
[ ] Biofeedback (EEG)
[ ] Chiropractic Care
[ ] Dietary Supplements
[ ] Other: _____

Please send completed form to Footsteps of Change, Inc. either via fax, mail, or email:
Fax: (256) 970-1294
Mail: P.O. Box 1522, Madison, AL 35758
E-Mail: inquiries@footstepsofchange.com

For Office Use Only:
Referral Source: _____
_____

Invigorating hope, one step at a time

For Office Use Only:
Date Received: _____
Staff Initials: _____