American Institute of Mental Health Inc. | ABA Referral Form
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AIMH-FRM-040 v1.1 | August 2026

Refer a Patient — Pediatricians, Schools & Specialists

Complete both pages, sign, and return with the attachments listed on page 2.

1. PATIENT

Patient full name: **Date of birth:** **Age:** **Sex:**

Home address: **City:** **ZIP:**

School / daycare (if any): **Grade:** **IEP / 504?** **Child's primary language:**

2. PARENT / LEGAL GUARDIAN

Guardian name: **Relationship:** **Phone:** **Email:**

Second contact (name): **Relationship:** **Phone:** **Best time to call:**

Preferred language for the family: ◯ English ◯ Spanish ◯ French ◯ Haitian Creole ◯ Other

Family knows about this referral: ◯ Yes — they expect our call ◯ Not yet — please introduce us

3. INSURANCE

Primary plan: **Member ID:** **Group #:** **Policy holder + DOB:**

Secondary plan (if any): **Member ID:** **Medicaid ID (if separate):**

4. DIAGNOSIS & CLINICAL PICTURE

Diagnosis / ICD-10 (all that apply): **Date of diagnosis:**

Diagnosis status: ◯ Confirmed — evaluation attached ◯ Suspected — evaluation needed

Diagnosing provider: **Current medications (name / dose):**

Other therapies now (speech, OT, PT — hrs/wk): **Previous ABA? (agency / when):**

Reason for referral & current concerns — behaviors, skills, communication, changes; anything that helps us triage:

Patient (same as page 1): **Date of birth:** **Referral date:**

5. REFERRING PROVIDER / SCHOOL

Name & credentials: **NPI:** **Phone:**

Practice / school: **Fax or email for our report back:**

Referral source: ○ PCP / pediatrician ○ Specialist ○ School ○ Family self-referral

6. SAFETY & URGENCY — check anything present (drives how fast we schedule)

☐ Aggression toward others ☐ Self-injurious behavior ☐ Elopement / wandering
☐ Pica / ingestion risk ☐ Feeding or severe food refusal ☐ No safety concerns reported

Urgency: ○ Routine ○ Expedited — placement at risk ○ Urgent — safety

7. SERVICES REQUESTED

☐ ABA assessment (97151) ☐ Direct ABA therapy (97153) ☐ Caregiver training (97156)
☐ Preferred setting: home ☐ Preferred setting: school / community ☐ Preferred setting: clinic

Days / times the family is generally available: **Anything we should know before we call:**

8. ATTACHED WITH THIS REFERRAL (check all that apply)

☐ Prescription / order for ABA ☐ Diagnostic evaluation / CDE ☐ Medical necessity letter
☐ Medical records / progress notes ☐ Insurance card (front & back) ☐ IEP / 504 (if school)
☐ Speech / OT / PT reports ☐ Prior ABA reports ☐ Other:

REFERRING PROVIDER SIGNATURE

Referring Provider / School Contact — Print Name Signature Date NPI (if applicable)

WHAT HAPPENS AFTER YOU SEND THIS

- Day 1-2 — Intake calls the family in their preferred language, confirms the referral and answers their questions.
- Day 2-5 — We verify benefits, request the authorization for the assessment (97151) and collect any missing document.
- Week 1-3 — A BCBA completes the comprehensive assessment: records review, caregiver interview, direct observation and standardized measures.
- After approval — Treatment begins, and we send the assessment summary and periodic progress updates to the fax or email you gave in section 5.

Send by fax (786) 388-0516 or email intake@americaninstituteofmentalhealth.com. A referral is complete with the prescription, the evaluation (or "evaluation needed" checked) and the insurance card. Questions about a referral in progress: (786) 652-6945. We accept Medicaid plans, most commercial plans and private pay; if the family is not eligible we tell you rather than leave the referral open.