Referral Form

Johnson Behavioral Services, PLLC

We currently provide services to children/adolescents with developmental disabilities, language delays, and behavioral needs. Services utilize ABA principles to promote language and functional communication in both structured and natural settings, minimize problem behavior, and teach functional replacement behaviors. The practice currently accepts BCBS and fee-for-service.

Patient Name:	Guardian Name(s):	
Gender ☐ M ☐F	DOB:	Phone:
Address:	Primary Insurance:	
Reason for Referral/Presenting Problem:		
Maladaptive Behaviors (Check all that apply): ☐Client has, or previously required, a behavior intervention plan ☐Client engages in behaviors that can be harmful to others ☐Client engages in self-injurious behaviors		
Current Medications, if any:		
Additional Comments/Concerns:		

Referring Physician/Professional (please complete or use address stamp):

Referring Provider: _____

Provider Phone: _____ Provider Fax: _____

Provider/Group Address: _____

Provider signature: _____ Date: _____

Please send referral to:

MAIL:
Johnson Behavioral Services, PLLC
1020 Crews Rd STE M
Matthews, NC 28105

or

FAX:
1-888-965-0596

Thank you for the referral.