



Consumer Specializing Service Request Form

Please send this form to the office of your choice

Boston Arbor Associates, 15 Court Square, Suite 1050, Boston, MA 02108

Worcester Arbor Associates, 51 Union Street, Worcester, MA 01608

Providence Arbor Associates, 1 Richmond Square, Suite 114K, Providence, RI 02906

Service Location _____

Street Address _____ City _____ State _____ Zip _____

Unit/Department/Bldg _____ Contact _____ Phone _____

Confirm Shifts With _____ Phone (D) _____ (N) _____

Contact at Service Location _____ Phone (D) _____ (N) _____

Consumer's Name _____ Age _____ DOB ____/____/____

Diagnosis _____ RX _____

Diagnosis Code _____ Reason for Specializing _____

Billing Information

Agency Responsible for Payment _____

Office to Bill _____ Billing Contact _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____

Authorization # _____ Credit Limit _____ Authorized through ____/____/____

Ordering Physician _____ Phone # _____

Additional Consumer Information

Consumer History (please include previous placements, pertinent issue, health problems, etc.) _____

Target Behaviors (frequency, patterns, etc.) _____

TX Plan and/or Behavior Programs _____

Suggested Activities (be specific as possible) _____

Special Skills Required _____

Brief Description of Service Location (setting, type of consumers, rules/guideline, etc.) _____

Directions To Assignment (by car and public transportation—use additional paper if necessary) _____

This Form was Completed By _____ Title _____

Contact Phone # _____ Date ____/____/____