



*Exceptionally Yours Autism & Educational Services
Referral Form*

Client Information

Client's Name _____ Age _____

Address _____
(Street Address) (City) (Zip Code) (County)

Parent/Guardian's Name(s) _____

Mother's Home# _____ Work/Cell# _____ Email _____

Father's Home# _____ Work/Cell# _____ Email _____

Additional Information: _____

Referral Source: _____ Phone# _____

Presenting issues bringing the child into treatment: _____

Name

Date

Please fax, email, or mail your referral form to:

Fax: (678) 868-1004 (HIPAA Compliant Box)*

Email: Administrative@eyaeservices.org

*Mail:
P.O. Box 784
Lithonia, GA 30058*