

PATIENT: Name: _____
 ID: _____ DOB: _____
 Address: _____
 City: _____ State: _____ Zip: _____

PROVIDER: _____ ID: _____
 Provider and Credential
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____

COORDINATION OF CARE:

	Yes	No
Parent/Caregiver is willing to participate in treatment:	<input type="checkbox"/>	<input type="checkbox"/>
I have communicated with patient's PCP or specialist:	<input type="checkbox"/>	<input type="checkbox"/>
I have communicated with patient's psychiatrist or therapist:	<input type="checkbox"/>	<input type="checkbox"/>
Child has an IEP in place:	<input type="checkbox"/>	<input type="checkbox"/>

DSM or ICD10 DIAGNOSIS (List Primary & Co-Occurring) code + description:

MEDICATIONS (attach if additional)
 Prescribed by PCP Psychiatrist APRN

- _____
- _____
- _____
- _____

If affective or psychotic disorder is present and no medications are prescribed, please explain:

RISK ASSESSMENT

<input type="checkbox"/> Suicidal	<input type="checkbox"/> Ideation	<input type="checkbox"/> Planned	<input type="checkbox"/> Imminent Intent	<input type="checkbox"/> History of self-harming behavior
<input type="checkbox"/> Homicidal	<input type="checkbox"/> Ideation	<input type="checkbox"/> Planned	<input type="checkbox"/> Imminent Intent	<input type="checkbox"/> History of behavior harming others

SYMPTOMS — if present, check degree or indicate N/A

	Mild	Mod.	Sev.	NA		Mild	Mod.	Sev.	N/A
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BEHAVIORS TARGETED FOR REDUCTION — if present, check degree or indicate N/A

	Mild	Mod.	Sev.	N/A		Mild	Mod.	Sev.	N/A
Self-injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phys. Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prop. Destruct.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Verbal Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threat Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Non-Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stereotypy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elopement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toileting Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inapp. Touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FUNCTIONAL IMPAIRMENT — if present, check degree or indicate N/A

	Mild	Mod.	Sev.	N/A		Mild	Mod.	Sev.	N/A
ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Functional Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TREATMENT PLAN

Parent/Caregiver training will be provided

Treatment providers are BCBAs, BCaBAs, and/or Registered Behavior Technicians under BCBA

For initial request for ABA services, must attach outcome of Functional Behavioral Assessment

For ongoing ABA services, must attach ADOS or evidence-based tool for ongoing services

#hours/week provided to date: _____

Level of improvement to date: Minor Mod Major None Chronic cond maintenance

Please indicate code type for billing and list all units/hours requested per month				
<input type="checkbox"/> HCPCS Code	<input type="checkbox"/> CPT Code	Service Type	Visits per Month	Hours/Units per Month
H0031 (per hour)	<input type="checkbox"/> 97151 <input type="checkbox"/> 97152	Treatment planning and assessment		
H0032 (per hour)	97155	Supervision by BCBA		
H2012 (per hour)	<input type="checkbox"/> 97156 <input type="checkbox"/> 97157	Parent training by BCBA		
H2012 (per hour)		Direct ABA services by BCBA		
H2019 (15min unit)	<input type="checkbox"/> 97156 <input type="checkbox"/> 97157	Parent training by paraprofessional		
H2019 (15min unit)	97153	Direct ABA services by paraprofessional		
H2014 (15min unit)	97154	Group skills training		
Other:	Other:	Other:		

This request for services is for: Initial ABA Request Continued ABA Services

Initial start date of this ABA episode of care: _____

Start date of ongoing services (*within 14 days of request): _____

Anticipated duration of ABA services remaining to meet treatment goals:

Less than 1 month 1 to 3 months 4 to 6 months more than 6 months

Provider Signature

Date

My signature confirms that I am providing the requested services and have completed this form accurately.