Early Intensive Behavioral Intervention Autism Spectrum Disorder Service Request Form

Health and Wellness Services P.O. Box 179, Duluth, MN 55801-0179
Fax form to: 1-866-938-9754

Patient Information

Patient name:	Provider Name:	Degree/License Type:
Patient address:	Clinic Name:	Provider Address:
Patient Phone:	Provider ID/NPI	Clinic ID (if applicable):
Subscriber Name:	Supervising Provider Name	Provider Phone:
Health Plan Name/Group #:	Supervising Provider ID:	Provider Fax:
Member ID:	Patient DOB:	Parent(s):

Axis I: Primary:
Secondary:
Axis II:
Axis III:
Axis IV:
☐ Economic problems
☐ Housing problems
☐ Occupational problems
☐ Other psychosocial problems
☐ Problems accessing health services
☐ Problems related to interactions with legal/criminal system
☐ Problems related to social environment or school
Axis V: (GAF) Current
Highest in last 12 months

Has the patient been evaluated for psychiatric meds. Within last 12 months? ☐ Yes ☐ No ☐ Patient Refused
Prescribing M.D. Name
List all current psychiatric medications/dose:

Treatment Information

Date of Last Assessment:	Is Assessment on File? Yes ☐ No ☐
Date Therapy Started:	Number of sessions to date:
Requested Number of hours/visits per week:	Dates Requested: From To Estimated Length of Treatment:
Supervising Mental Healthcare Professional:	Lead Behavior Therapist:
Multi-disciplinary Team Members & credentials:	
Parent/guardian authorizes treatment: Yes ☐ No ☐ Parent Education and Support Services Available:	

Education Information

Please answer these questions if the patient is age six (6) or above

School attended (hours per day):
Indicate coordination plan with educational system:

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Treatment Plan
- Sample -

Goal #1: (i.e. Coping Behavior, Cognitive, Receptive Language)

Date	Objective	Strategy	Progress towards Outcome	Projected Date of Mastery
Initial ITP Plan Date (i.e. 8/1/09)	Should state activity and optimal quantitative result *(i.e. Will actively rely on adults to solve problems and meet needs 80% of time)*	Should state the methods involved with helping the patient reach his/her objective *(i.e. Use of visual cues and prompts*		The estimated date when the patient should be able to master the objective.
First Review Date (180 days) (i.e. 2/1/10)			This would be filled in as progress is achieved. This section would be used to record progress made at the 6-month concurrent review intervals. **This section must include some content, even if it indicates that the goal has been suspended.**	
Second Review Date (180 days) (i.e. 8/1/10)			This would be filled in as progress is achieved. This section would be used to record progress made at the 6-month concurrent review intervals. **This section must include some content, even if it indicates that the goal has been suspended.**	

The Treatment plan section could go on to include as many goals as the provider wishes to identify and work on.

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Treatment Plan

Goal # :

Date	Objective	Strategy	Progress towards Outcome	Projected Date of Mastery
Initial Request				
Review #1				
Review #2				
Review #3				

Please make additional copies of this page for subsequent treatment goals.

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Discharge Planning

Signatures

____________________________________ ____________
Clinical Supervisor / credentials Date

____________________________________ ____________
Lead Behavior Therapist/credentials Date

____________________________________ ____________
Parent/Guardian Signature Date