



Early Intensive Behavioral Intervention Autism Spectrum Disorder Service Request Form

BlueLink TPA , Attention: *Behavioral Health Care Management*
P.O. Box 64265, St Paul, MN 55164-0265, Mail Route: R4-72
Fax: 651-662-0854

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):
<p>Axis I: Primary: Secondary:</p> <p>Axis IV: <input type="checkbox"/> Economic problems <input type="checkbox"/> Housing problems <input type="checkbox"/> Occupational problems <input type="checkbox"/> Other psychosocial problems</p> <p>Axis V: (GAF) Current</p>		
<p>Axis II: Axis III:</p> <p><input type="checkbox"/> Problems accessing health services <input type="checkbox"/> Problems related to interactions with legal/criminal system <input type="checkbox"/> Problems related to social environment or school</p> <p>Highest in last 12 months</p>		
<p>Has the patient been evaluated for psychiatric meds. Within last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient Refused</p> <p>Prescribing M.D. Name</p> <p>List all current psychiatric medications/dose:</p>		

Treatment Information

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

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:



Early Intensive Behavioral Intervention Autism Spectrum Disorder Service Request Form

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>(i.e. Will actively rely on adults to solve problems and meet needs 80% of time)</i>	Should state the methods involved with helping the patient reach his/her objective <i>(i.e. Use of visual cues and prompts)</i>		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.



Early Intensive Behavioral Intervention Autism Spectrum Disorder Service Request Form

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.



Early Intensive Behavioral Intervention Autism Spectrum Disorder Service Request Form

Discharge Planning

Signatures

Clinical Supervisor / credentials

Date

Lead Behavior Therapist/credentials

Date

Parent/Guardian Signature

Date