

Referral for Applied Behavior Analysis

Patient name: _____

DOB (mm-dd-yyyy): _____ Member Subscriber #: _____

Referring provider: _____

NPI: _____

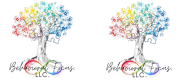
Initial ASD diagnosis date: _____

Service(s) requested:



Units	Frequency (per day/ week/month)	CPT code	Description
24 units	30-day period	97151	*Includes behavior identification assessment, treatment planning and is limited to 6 hours (24 units) for initial evaluation.

I am referring _____ for an ABA Assessment, 97151 for 6 hours, 24 units to be conducted at Behavioral Focus, LLC.



DSM-5 criteria	Autism Spectrum Disorder		
Note: If the individual has a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or PDD-NOS, please check this box. Complete the below checklist to reclassify the previous diagnosis to Autism Spectrum Disorder.	_____		
A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (all 3 must be met):	Present	Not present	
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.	—	—	
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.	—	—	
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.	—	—	
Social communication domain severity rating (check one)[see DSM-5 page 52 for severity description]): (1) Requires support (2) Substantial support (3) Very substantial support	(1) <input type="checkbox"/>	(2) <input type="checkbox"/>	(3) <input type="checkbox"/>
B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following, currently or by history:	Present	Not present	
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).	<input type="checkbox"/>	<input type="checkbox"/>	
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).	<input type="checkbox"/>	<input type="checkbox"/>	
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).	<input type="checkbox"/>	<input type="checkbox"/>	
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).	<input type="checkbox"/>	<input type="checkbox"/>	
Restricted, repetitive behaviors domain severity rating (check one)[see DSM-5 page 52 for severity description]): (1) Requires support (2) Substantial support (3) Very substantial support	(1) <input type="checkbox"/>	(2) <input type="checkbox"/>	(3) <input type="checkbox"/>
	Yes	No	



C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).	<input type="checkbox"/>	<input type="checkbox"/>
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.	<input type="checkbox"/>	<input type="checkbox"/>
E. These disturbances are not better explained by intellectual disability or global developmental delay.	<input type="checkbox"/>	<input type="checkbox"/>
DSM-5 criteria		
Autism Spectrum Disorder criteria met?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
With or without intellectual impairment?	With <input type="checkbox"/>	Without <input type="checkbox"/>
With or without language impairment?	With <input type="checkbox"/>	Without <input type="checkbox"/>

Referring Provider name: _____

Provider credentials and NPI: _____

Signature: _____ Date: _____