Outpatient Applied Behavior Analysis Treatment Report

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

PROVIDER: _____ ID: _____
Individual Provider
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

COORDINATION OF CARE:

	Yes	No	N/A
Parent/Caregiver is participating in treatment:	☐	☐	☐
I have communicated with patient's PCP or specialist:	☐	☐	☐
I have communicated with patient's psychiatrist or therapist:	☐	☐	☐

DSM DIAGNOSIS numeric + description:
Axis I _____
Axis II _____
Axis III _____

PSYCHOTROPIC MEDICATIONS
Prescribed by ☐ PCP ☐ Psychiatrist ☐ APRN
1. _____
2. _____
3. _____
4. _____
If affective or psychotic disorder is present and no medications are prescribed, please explain:
_____

RISK ASSESSMENT
☐ Suicidal ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ History of self-harming behavior
☐ Homicidal ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ History of behavior harming others

SYMPTOMS — if present, check degree or indicate Resolved/NA

	Mild	Mod.	Sev.	Resolved/NA		Mild	Mod.	Sev.	Resolved/NA
Anxiety	☐	☐	☐	☐	Inattention	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Obsessions	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	Sleep Disturbance	☐	☐	☐	☐

BEHAVIORS TARGETED FOR REDUCTION — if present, check degree or indicate Resolved/NA

	Mild	Mod.	Sev.	Resolved/NA		Mild	Mod.	Sev.	Resolved/NA
Self-injury	☐	☐	☐	☐	Phys. Aggression	☐	☐	☐	☐
Prop. Destruct.	☐	☐	☐	☐	Verbal Aggression	☐	☐	☐	☐
Threat Making	☐	☐	☐	☐	Non-Compliance	☐	☐	☐	☐
Tantrums	☐	☐	☐	☐	Stereotypy	☐	☐	☐	☐
Elopement	☐	☐	☐	☐	Toileting Issues	☐	☐	☐	☐
Inapp. Touch	☐	☐	☐	☐	Other:_____	☐	☐	☐	☐

FUNCTIONAL IMPAIRMENT – if present, check degree or indicate Resolved/NA

	Mild	Mod.	Sev.	Resolved/NA		Mild	Mod.	Sev.	Resolved/NA
ADLSs	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Family/Relationships	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Functional Communication	☐	☐	☐	☐	Other:_____	☐	☐	☐	☐

DEFINITION OF SUCCESSFUL TREATMENT
(See attached Progress Report for detailed outcomes)
Desired observable outcome #1: _____
Desired observable outcome #2: _____
Desired observable outcome #3: _____
Desired observable outcome #4: _____

LEVEL OF IMPROVEMENT TO DATE
Sessions provided to date: _____
☐ Minor ☐ Moderate ☐ Major ☐ No progress to date ☐ Maintenance tx of chronic condition
Start date for new authorization (cannot be more than 30 days from submission) _____
Initial start date of this episode of care: _____

PROVIDER'S CONTINUED TREATMENT PLAN (requested services)

MODALITIES	FREQUENCY	ANTICIPATED COMPLETION
☐ Individual	☐ Weekly	☐ Less than 1 month
☐ In-home	☐ Twice per month	☐ 1 to 2 months
☐ Community based	☐ Monthly	☐ 2 to 4 months
	☐ Less than monthly	☐ More than 4 months

HOURS RECOMMENDED PER MONTH/WEEK: CPT CODE 1:
HOURS RECOMMENDED PER MONTH/WEEK: CPT CODE 2:
HOURS RECOMMENDED PER MONTH/WEEK: CPT CODE 3:

_____ _____
Provider Signature Date
My signature confirms that I am providing the requested services

FAX to: 206-613-8873 **PHONE: 800-440-1561**