The EDINBURG CENTER

Children's Services (ABA) Intake (781) 761-5060 Fax: 781-275-7207

205 Burlington Road • Bedford, MA 01730

Date:

Autism ABA Referral Form (MassHealth)

1: Youth Information:			
Youth Name:			
Address:			
City:	State:	Zip:	
Date of Birth: Age:	Ethnicity:	Gender:	
Primary form of communication:			

2: Parent/Guardian & Family Information			
Parent/Guardian Name:		Relationship:	
Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email address:			
Parent/Guardian Name:		Relationship:	
Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email address:			
Foster Family ☐ Yes ☐ No		Adoptive Family ☐ Yes ☐ No	
Primary Language Spoken at Home:		Spoken by youth:	
Safety concerns in-family: ☐ Yes ☐ No neighborhood ☐ Yes ☐ No (describe on separate sheet)			
Siblings names, ages, gender:			
Names of other adults living in the house:		Caregiver?	
_____		☐ Yes ☐ No	
_____		☐ Yes ☐ No	

Family Availability		
Days of the Week:	Start time:	End Time:
Monday		
Tuesday		

Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

3: Insurance Information:

MassHealth # (MMIS): MCE # (if applicable):

MassHealth MCE (Behavioral Health) plan (circle one):

MBHP Tufts-Network Neighborhood (NHP) Fallon BMC (Boston Medical)

Commercial Insurance & #:

4. Medical Necessity Criteria:

1. Does the youth have definitive diagnosis of ASD,(DSM 5) ☐ Yes ☐ No
2. Has the youth been diagnosed by a licensed physician or psychologist? ☐ Yes ☐ No
3. Has the youth received a comprehensive diagnostic and/or functional assessment? (please attach) ☐ Yes ☐ No
4. Does youth exhibit atypical or disruptive behavior that significantly interferes with daily functioning and activities or that poses a risk to the member or others related to aggression, self-injury, property destruction etc.? ☐ Yes ☐ No
5. The diagnostic report clearly states the diagnosis and the evidence used to make diagnosis: ☐ Yes ☐ No
6. Initial evaluation from a licensed Applied Behavior analyst supports the request for ABA services ☐ Yes ☐ No

Please attach at least one assessment tool defining medical necessity for ABA services

☐ **Release of Information (if not parent)** Copy attached: ☐ Yes ☐ No

☐ **Developmental Pediatrician Evaluation** Copy attached: ☐ Yes ☐ No

☐ **Neuro-Psych report** Copy attached: ☐ Yes ☐ No

☐ **Other Medical Assessment** Copy attached: ☐ Yes ☐ No

5: Medical Information:

Diagnoses:		
When was the youth diagnosed (date/age)?		
Who made the diagnosis (name/title)		
Practice/Agency:		
Address:		Phone:
Primary Physician:		Phone:
Practice Name:		
Address:		
City:	State:	Zip:

Please attach latest physical and immunization record	Copy attached: ☐ Yes ☐ No
Name & describe any youth medical concerns:	
Does youth have allergies (list type):	
Does youth have history of seizures:	
Describe any youth physical disabilities:	
Does youth take medication (list name, dosage and times):	

6: Others involved with youth:	
Developmental Pediatrician: Facility:	Phone:
Prescriber: Facility:	Phone:
Speech Therapist: Facility:	Phone:
Occupational Therapist: Facility:	Phone:
Physical Therapist: Facility:	Phone:
In Home Support: Facility:	Phone:
State Agency (DDS, DMH or DYS): Worker:	Phone:
Other:	Phone

7: School Information:		
Daycare/School/EI name:		Grade:
Address:		
City:	State:	Zip:
School contact name:	Phone:	
Type of classroom (circle one): self-contained Inclusion Reg Ed Home based		
Date of last IEP:	Copy attached: ☐ Yes ☐ No	
School Behavior Support Plan: ☐ Yes ☐ No	Copy attached: ☐ Yes ☐ No	

8: Behavioral History

Does the youth display any of the following behaviors (circle)

Verbal aggression Physical aggression Self-injury Non-compliance Destruction of Property

Inflexible routines or rituals Stereotypy (self-stimulating behaviors) Eating/mealtime behaviors

Sleeping/bedtime issues Tantrumming Bolting Other _____

Please describe what the behaviors look like:

How often do the behaviors occur? (specify frequency per day/week, length and level of intensity)

Describe how the behaviors are currently handled:

How effective are the procedures in: a) stopping behavior b) decreasing/increasing the frequency or intensity of the behaviors

Do any behaviors occur at school? If so, which ones:

Has the youth been hospitalized, CBAT, placed residentially or used emergency respite in the last two years? Briefly explain:

Is the youth toilet-trained? ☐ Yes ☐ No

9: Referral source (if other than parent/guardian)		
Referral Name:		Relationship:
Agency/Practice/Facility:		
Address:		
City:	State:	Zip:
Work Phone:	Cell Phone:	
Email address:		