HealthPlan OF SAN MATEO
Healthy is for everyone

Magellan HEALTHCARE

Applied Behavioral Analysis (ABA) Screening Form

Patient Name: _____

DOB: _____ **Language:** _____

Name of Referring Provider: _____

Please indicate which types of documentation you have reviewed: (select all that apply)

- ☐ Recent treatment plan from patient's ABA provider
- ☐ Individual Education Plan (IEP) with diagnostic testing detailed
- ☐ Diagnostic report
- ☐ Diagnostic report from a licensed professional (PhD, PsyD, MD), created more than 24 months ago
- ☐ Diagnostic report from a non-licensed professional, any time period

Please indicate any concerns expressed by the parent during interview: (select all that apply)

- ☐ Lack of expressive communication
- ☐ Poor eye contact
- ☐ Self-stimulatory behaviors (i.e. rocking back and forth, hand flapping, humming, etc.)
- ☐ Self-injurious behaviors (i.e. biting self, hitting self, etc.)
- ☐ Elopement (running away from home/parent)
- ☐ Non-compliance
- ☐ Excessive crying/whining/tantrums (outside of age normative levels)

After review of the patient documentation and parent interview the following have been confirmed: (select one)

- ○ **Diagnosis of Autism and a recommendation of ABA (Attach report)**
- ○ **Diagnosis of Autism and no recommendation of ABA**

  Other services that are more appropriate are: _____
- ○ **CDE needed to determine if member has Autism**
- ○ **No diagnosis of Autism; follow up testing to rule out**

  Other mental/behavioral health concerns: _____

Name (print)	Signature	Date Signed