Behavioral Health (BH) Care – Autism Evaluation, BHT/ABA Referral Form

The Alameda Alliance for Health (Alliance) Autism Evaluation, BHT/ABA Referral Form is confidential. This form must be completed by a physician, pediatrician, neurologist, or licensed clinical psychologist (e.g., MD/DO/ PhD/PsyD). Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below. All sections in this form are required.
2. In **Section 3**: Please provide your email address to allow the Alliance to confirm receipt of your referral and provide authorization status updates.
3. Please attach all pertinent screening forms used and relevant medical records to this form and indicate which screening tool(s) you are attaching/submitting with this referral form.
4. Please fax the completed form along with all pertinent clinical documents to the Alliance Behavioral Health Department at **1.855.891.9163** or send a secure email to **deptbhaba@alamedaalliance.org**.

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

PLEASE NOTE: If the member has other case management or care coordination needs aside from ABA/BHT (e.g., referral to a social worker, speech therapy, occupational therapy, complex case management, etc.), please complete the Alliance Case Management (CM) Program Referral Form. To download the form, please visit the Alliance website at **www.alamedaalliance.org**. For inquiries regarding Alliance CM Program, please call the Alliance Case and Disease Management Department at **1.510.747.4512** or toll-free at **1.877.251.9612**.

SECTION 1: SCREENING TOOLS

Select the screening tool that was conducted prior to this referral (at least one (1) is required):

- ☐ Modified Checklist for Autism in Toddlers (M-CHAT)
- ☐ Survey of Well-being of Young Children (SWYC)
- ☐ Other: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Phone Number: _____

Primary Language Spoken by Caregiver(s)/Parent(s): _____

Require Interpreter: ☐ Yes ☐ No Alliance Member ID #: _____

SECTION 3: REFERRING PROVIDER INFORMATION

Organization Name: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

License #: _____ License Type: _____

Phone Number: _____ Fax Number: _____

Email: _____

SECTION 4: EVALUATION/REFERRAL INFORMATION

Behavioral symptoms and concerns (e.g. behavioral excesses/deficits) (please select all that apply):

- ☐ Confirmed cognitive delay
- ☐ Echolalia (repetition of words or sounds made by another person)
- ☐ Elopement
- ☐ Inappropriate physical behaviors toward others
- ☐ Limited or no eye contact during social interactions
- ☐ Limited peer interaction/social response
- ☐ Preoccupation of interests
- ☐ Repetitive behaviors
- ☐ Restricted patterns of behaviors
- ☐ Self-injurious behaviors
- ☐ Speech delay
- ☐ Stereotypic movements
- ☐ Suspected cognitive delay
- ☐ Other: _____

Based on your screening and evaluation, are you recommending/referring the member for any of the following services/assessments (please select all that apply):

- ☐ Applied Behavior Analysis (ABA) Treatment
- ☐ Diagnostic Evaluation/Psychological Assessment to rule out autism
- ☐ Mental Health Assessment and services
- ☐ Other: _____

Please list all *established* diagnoses:

Please list all *suspected* diagnoses:

Please describe any medical condition/diagnosis (e.g., genetic disorders, neurological disorders, etc.) that could be contributing to behavioral excesses or deficits described above:

Does the member have a history of receiving ABA? ☐ Yes ☐ No ☐ Not Sure

SECTION 5: ADDITIONAL INFORMATION

Please provide any additional information you would like to communicate to the behavioral health care provider or Alliance care manager:

SECTION 6: REFERRING PROVIDER SIGNATURE

Full Name (Print): _____

Signature: _____ Date: _____