Hummingbird Beahvioral Health

Children's Referal Form

Date:

Youth Information

Name: M/F

DOB: Age:

Adress: City: ZIP:
Mailing Adress:

Primary form of communication:

Parent/Gardian Information

Name: Relationship:

Adress: City: ZIP:
Mailing Adress:

Phone Number: Email:

Parent/Gardian Information

Name: Relationship:

Adress: City: ZIP:
Mailing Adress:

Phone Number:	**Email:**

Primary Language Spoken at Home:	**Spoken By Youth:**

Safety Concerns: ⬭ AT HOME ⬭ NEIGBORHOOD ⬭ SCHOOL (EXPLAIN)

SCHOOL INFORMATION		
Name: Type of classroom:	Grade:	
Adress:	City:	Zip:
School Contact Name: Phone:	Email:	
Date of Last IPE:	Copy Attached ⬭	
School Behavior Support Plan: YES NO	Copy Attached ⬭	

Others Involved with you:	
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

Behavioral History:

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

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

Insurance Information:
Check Type of Members Primary Insurance and Complete Plan Information: ☐ CO Medicaid ☐ Insurance Carrier: Group/Policy Number: Effective Date: ☐ Not Applicable, member does not have other primary insurance

Referral Source:

Referral Name:		Relationship:
Agency/Practice/Facility:		
Address:		
City:	State:	Zip:
Work Phone:	Cell Phone:	
Email address:		