PHOENIX Behavioral Health Services LLC
3120 Memorial Drive Two Rivers, WI 54241 Phone (920)657-1780 Fax (920)657-1784 www.phoenixbhc.com

PRE-ASSESSMENT FOR AUTISM SERVICES

Client Name:		**Today's Date:**	
Date of birth:		**Age (yr:mo):**	
Address, City:	**Phone Number:**	**Primary Funding Source:**	**Secondary Funding Source:**
Referral source:			

Family Supports and Living Arrangements

Name	Relationship to Client (Parent, Guardian, Grandparent, Sibling, etc.)	Full-time / Part – time _____%
Other family supports that do not live with client:		
Notes on supports and living arrangements:		
Notes on spiritual beliefs that may impact treatment:		
Notes on cultural beliefs that may impact treatment:		

Diagnostic History

Provider of diagnosis	Date	Diagnosis/results

School Information

Service	Name of School	Speech	OT	PT	Other
Early Childhood					
Elementary School					
Middle School					
High School					
Current School & Grade:					

Past Therapies / Interventions

(Birth-3, behavioral treatment, speech therapy, occupational therapy, physical therapy, daily living skills training, psychotherapy, psychiatry, etc.)

Type	Name of Agency, City/State	Name – Person who supervised treatment	Start Date	End Date	Results / Effectiveness	Reason for Discontinuing (if applicable)

Current Therapies / Interventions

(Birth-3, behavioral treatment, speech therapy, occupational therapy, physical therapy, daily living skills training, psychotherapy, psychiatry, etc.)

Type	Name of Agency, City/State	Name – Person who supervised treatment	Start Date	End Date	Results / Effectiveness

Other Current Supports – Care Collaboration

Agency	Name of Professional	Current Services Provided	Frequency of Interventions
County Waiver Agency			
Birth-3 / Early Intervention			
School District			
Outside Therapy			
Other			

Personal and Medical Background Notes

(allergies, medications, hospitalizations, sleep, eating, developmental milestones: sitting up, crawling, walking, talking, etc..)

Was pregnancy and delivery of child typical/healthy?	**Yes** **No**	**If no, describe medical challenges during these time periods:** **Vaginal or C-Section delivery:**
Child was born at 40 weeks gestation?	**Yes** **No**	**If no, describe number of weeks of gestation until birth and why early delivery occurred:**
Does your child have any allergies?	**Yes** **No**	**If yes, list allergies:**
Is your child on any medication?	**Yes** **No**	**If yes, list medications:**
Has there been anything significant in your child's medical history?	**Yes** **No**	**If yes, summarize medical history:**
Does your child have any difficulty with sleep or eating?	**Yes** **No**	**If yes, describe problem areas:**

Did your child hit developmental milestones in a timely fashion (walking, talking, etc)?	**Yes** **No**	**If no, describe delays:**

Presenting Problems / Current Concerns / Priorities for Treatment
(What are your main goals for therapy?)

CLIENT PROFILE

Client Interests
(Please list at least 3 interests your child has)

1. **2.** **3.**

Communication

What is your child's primary mode of communication?	Describe:
Does your child display understanding of receptive language?	Describe:
Describe your child's expressive language?	Describe:
Does your child have/utilize conversation skills?	Describe:
Does your child understand non-verbal communication?	Describe:

Play/Social Interaction

How does your child typically play?	Describe:
Does your child show interest in peers?	Describe:
Does your child play with peers?	Describe:
Does your child verbally communicate with peers?	Describe:
Does your child understand emotions?	Describe:
Is your child able to take others' perspective?	Describe:

Daily Living

Do you currently have any safety concerns regarding your child?	Describe:
Does your child engage in self-help skills?	Describe:
Is your child toilet trained?	Describe:
Describe any independent skills your child has.	Describe:

Behavioral Concerns

Does your child have any sensory sensitivities?	Describe:

What does distress look like?	Describe:
What are triggers for problem behavior/distress?	Describe:
Does your child have any coping / calming strategies?	Describe:

Other Notes / Questions / Concerns (Are there any issues that may become barriers to treatment?)

What's next?

1. Fill out the availability form on page 6.
2. Mail pre-assessment packet to Cheryl
3. Cheryl will share pre-assessment packet with BCBA to review. If services are deemed appropriate, the intake process will move forward with steps 3-8). If it is determined Phoenix would not be a good fit for your child, Cheryl will call with determination and share resources with family for other services.
4. Obtain copies of diagnostic assessment and IEP (give to BCBA at intake appointment).
5. Katie (Intake and Training Coordinator) will call to set up an Initial Intake Assessment (2-hours).
6. Katie and BCBA will complete 2-hour Initial Intake Assessment (In your home).
    a. Please have your child available for this assessment.
    b. Plan for paperwork to be completed with Katie and an interview to be completed with BCBA.
7. Katie will schedule a Follow-Up Assessment to introduce your assigned Treatment Therapist (the individual who manages your child's treatment).
    a. They will work directly with your child during this 2-hour appointment after meeting you and answering any follow-up questions you may have.
8. Treatment Therapist and BT will do 2-hour per day Follow-up Assessments 2-5 days per week for approximately 4 weeks while waiting for the prior authorization.
9. Once prior authorization is place, services start based on an agreed upon schedule.

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Preferred Schedule

At Phoenix, we have started to utilize what we call "Block Scheduling." By utilizing this system we do our best to provide uniformity to our morning, afternoon, and afterschool scheduling. We value our employees and feel that "Block Scheduling" will allow us to provide our staff with periodic breaks throughout the day, opportunities to meet with Treatment Therapists on a more regular basis to discuss client care, and have greater access to staff development. As the turnover rate of Behavioral Technicians is on the rise across the nation our hope is that these options will decrease therapy fatigue and increase a positive work environment. Our employees are amazing individuals who share an intrinsic desire to help the clients they work with achieve maximum results. As employers, we are listening to their concerns and attempting to meet their needs.

	Monday	Tuesday	Wednesday	Thursday	Friday
Follow-up Assessment *The prior-authorization period takes approximately 1-month to complete. During this time, your assigned Treatment Therapist and Behavior Technician can come to your home to work with your child for 2 hours per day until services can begin. Please circle or highlight the times that would work best for your child to be available for follow-up assessment.*	8:00a-10:00a	8:00a-10:00a	8:00a-10:00a	8:00a-10:00a	8:00a-10:00a
	10:00a-12:00p	10:00a-12:00p	10:00a-12:00p	10:00a-12:00p	10:00a-12:00p
	9:00a-11:00a	9:00a-11:00a	9:00a-11:00a	9:00a-11:00a	9:00a-11:00a
	11:00a-1:00p	11:00a-1:00p	11:00a-1:00p	11:00a-1:00p	11:00a-1:00p
	1:00p-3:00p	1:00p-3:00p	1:00p-3:00p	1:00p-3:00p	1:00p-3:00p
	2:00p-4:00p	2:00p-4:00p	2:00p-4:00p	2:00p-4:00p	2:00p-4:00p
	3:00p-5:00p	3:00p-5:00p	3:00p-5:00p	3:00p-5:00p	3:00p-5:00p
	3:30p-5:30p	3:30p-5:30p	3:30p-5:30p	3:30p-5:30p	3:30p-5:30p
	4:30p-6:30p	4:30p-6:30p	4:30p-6:30p	4:30p-6:30p	4:30p-6:30p
	5:00p-7:00p	5:00p-7:00p	5:00p-7:00p	5:00p-7:00p	5:00p-7:00p
Notes:					

If your child is between the ages of 2.5 years and 5 years it is likely that your assigned BCBA will make the clinical recommendation that your child receive 25-40 hours per week of therapy. If your child is elementary school-aged it is likely your BCBA will recommend between 15-20 hours per week. If your child is middle school-aged and has a history of service, it is likely your BCBA will recommend between 6-12 direct hours per week. Please provide a range of hours your child will be available for therapy (examples: 8:00a-3:00p, 8:00a-12:00p, 3:00-7:00p), their school schedule, and any other therapies and/or extracurricular activities they are participating in on the schedule below.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
School						
Therapy						
Other						
Notes:						

I verify that the above schedule was completed by me, _____ (full name) and that I will not change my child's availability until Phoenix changes their schedules (3 times per year; spring, summer, and fall). I understand that changing my child's availability may impact Phoenix's ability to deliver services.

_____
Signature