Functional Behavioral Assessment Request Form

PATIENT: Name: _____

ID: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

PROVIDER: _____ ID: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

DSM or ICD 10 DIAGNOSIS (code + description)- BH and Medical

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS (attach if additional)

Prescribed by: ☐ PCP ☐ Psychiatrist ☐ APRN

1. _____
2. _____
3. _____
4. _____

PLEASE ATTACH THE FOLLOWING INFORMATION:

☐ Copy of prior Autism Spectrum Disorder Evaluation completing by a Developmental Pediatrician, Neurologist, Psychiatrist, or Licensed Psychologist

☐ Results of comprehensive History & Physical completed within the last 6 months

FBA SERVICES* REQUEST

Date of Functional Behavioral Assessment to begin: _____

*Services must be provided by a Board Certified Behavior Analyst (BCBA) or by a Board Certified Assistant Behavioral Analyst (BCaBA) or Registered Behavior Technician (RTC) under the supervision of a BCBA.

Anticipated Duration of Functional Behavioral Assessment:

☐ 2 weeks ☐ 4 weeks ☐ Other (describe): _____

Estimated Visits/Week: _____

Total Hours/Visit: _____

☐ 0359T (untimed)

☐ 0360T (first 30mins each visit) + 0361T (each additional 30mins)

☐ H0031 (per hour)

☐ Other (provide): _____

_____

_____ _____

Provider Signature Date

My signature confirms that I am providing the requested services

FAX to: 888-974-5948 | Health Integrated, 10008 North Dale Mabry Hwy., Tampa, FL 33618 | **PHONE:** 888-211-6922