



## Plan For the Treatment and Concurrent Review of Autism Spectrum Disorders

Treatment Plan Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_

Beginning Date of Treatment Services: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

### Provider Information

Name: \_\_\_\_\_

Chief Clinical Officer: \_\_\_\_\_

Street Address: \_\_\_\_\_

Name of Practitioner Supervising Treatment: \_\_\_\_\_

### Assessment and Treatment Approach and Ancillary Therapies

Daily Schedule:

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Behavior	Definition	Previous Level	Current Level	Goal
Tantrum				
Physical aggression				
Elopement				
Non compliance				
Property Destruction				
Verbal Aggression				
Other Behaviors not listed above				

**Behavioral Progress Summary**

### Behaviors Targeted for Increase

Behavior	Goal	Objectives	Current Level
Manding			
Tacting			
Listener Responding			
Visual Perceptual Skills and Matching to Sample			
Social Skills			
Listener Responding by Feature,Function and Class			
Intraverbal			
Linguistic Structure			

### Progress Summary

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**Crisis Management**

Blank area for Crisis Management plan.

**Educational Plan (if applicable)**

Blank area for Educational Plan (if applicable).

**Transition/Discharge Plan**

Blank area for Transition/Discharge Plan.

Requesting Therapist:

\_\_\_\_\_ Printed Name

\_\_\_\_\_ Signature