



**Autism Spectrum Progress Report – confidential**  
**Please Fax to Stefanie Statz at: 608-226-4777**

**Provider: Please select level of service:**  
 \_\_\_\_\_ **Intensive Service Level**  
 \_\_\_\_\_ **Non-Intensive Service Level**

**Demographics**

Patient's Name:		D.O.B.		Sex:	_____	Male	_____	Female
Subscriber #:		Provider Name:						

**History/Background**

Medical Diagnosis (es)			Mental Health Diagnosis (es)		
When was patient diagnosed with Autism?	Date:		Who made the diagnosis?		Provider name/telephone #
How was the Diagnosis made? List specific tools used or referenced in making the determination.			Specific Symptoms (including duration and intensity) associated with Autism Spectrum Diagnosis:		
Who lives with the Patient (please include names, relationships, and ages of siblings)?			Where does the patient spend the majority of his/her day (day care, parent(s), relatives, school, etc)?		
Name(s):		Relationship:		Age:	
Do the parent(s) work outside the home? <input type="checkbox"/> Yes <input type="checkbox"/> No; Other _____			If so, how many days per week and hours per day. _____		

**What Treatment has the patient been receiving to date:** (please complete below)

Provider Name:	Dates of service: Start/Finish	What services were provided? How involved were the parents?	How often?	If a gap in service, please explain.

Has this patient received any services through the waiver program?  No  Yes; please explain:



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Has this patient been on the waiting list for the Waiver Program?  
If so, how long? What has been done while on the waiting list?

No  Yes How long?  
What has been done while on the waiting list?

Have the parent(s), primary care givers, teachers completed a written and/or oral assessment of their concerns regarding the patient?  
 No  Yes details:

**Assessment**

**What are the primary concerns/issues to be addressed?**

- 1)
- 2)
- 3)
- 4)
- 5)

What is the degree of language impairment?

Degree of cognitive impairment?

Presence of non-specific behavioral disorders (e.g. eating, sensory, tolerance for pain, eye contact, etc)?

What are the current stressors in this patient's life? (e.g. divorce, separation, death in the family, loss of pet)

How do you, the provider, determine if progress is being made?



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How is progress measured?

At what point is a new approach/therapy tried?

What is the prognosis of the current treatment approach? (based on?)

Medication:		Dosage:		Medication:		Dosage:	
Medication:		Dosage:		Medication:		Dosage:	
Medication:		Dosage:		Medication:		Dosage:	

When is the planned stop date for treatment? How will you know? How often will care be reviewed? By whom?

<b>Has the patient tried any of the following?:</b>			
Acupuncture: <input type="checkbox"/> No <input type="checkbox"/> Yes	Animal Based Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes	Auditory Integration Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes	Chelation Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes
Cranial Sacral Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes	Hyperbaric Oxygen Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes	Special Diets or Supplements: <input type="checkbox"/> No <input type="checkbox"/> Yes	Other: