

**Adaptive Behavior Assessment System (ABAS) Referral Information**

**\*\*Accepting only FULL Maine Care\*\***

**This does not include Katie Beckett**

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| Date: | Referred by: | | | | | | | | | | DOA: | | OCS #: | |
| Child’s Name: | | | | D.O.B.: | | | Age: | | | | Gender: | | Grade: | |
| Primary Language Spoken:  Interpreter Needed:  Yes  No | | | |
| Parent/Guardians: | | | | Guardian address: | | | | | | | | | | |
| Primary Language Spoken:  Interpreter Needed:  Yes  No | | | |
| Guardian Contacts:  Phone:  Cell:  Email:  Check preferred method of contact | | | | | | | | | | Mainecare ID Number: | | | | |
| **Primary Care Physician**   Check if referring person | Name: | | | | | | | Phone:  Fax: | | | | | | |
| **Psychiatrist:**   Check if referring person | Name: | | | | | | | Phone:  Fax: | | | | | | |
| **Counselor/ Therapist:**   Check if referring person | Name: | | | | | | | Phone:  Fax: | | | | | | |
| **Caseworker/ Case Mgr:**   Check if referring person | Name:  Agency: | | | | | | | Phone:  Fax: | | | | | | |
| **Other Professional:**   Check if referring person | Name:  Type: | | | | | | | Phone:  Fax: | | | | | | |
| **School:** | Name:  Homeschooled | | | | | | | District: | | | | | | |
| **Current Diagnoses:** | | | | | **Current Medications:** | | | | | | | | | |
| **Current Services**  Check all that apply | School IEP/Special Ed  School 504 Accommodations  School Counselor  Tutoring  Occupational Therapy  Speech Therapy  Physical Therapy  Vision Therapy  Naturopathy  HCT  BHP  VRT  MST  Psychotherapy  Behavior Therapy (e.g., ABA)  Group Therapy  Social Skills training  Other- Describe: | | | | | | | | | | | | | |
| **Current Status**  Check all that apply | DHHS Involvement  Foster Care  Adoption Process  JSOP/Probation Supervision  Incarcerated | | | | | | | | | | | | | |
| **Reason for ABAS-3 Referral** | Current concerns/ Identified Issues / Duration of problems / Progress in treatment | | | | | | | | | | | | | |
| **Developmental History** | Were there any significant developmental difficulties | Prenatal | Infancy (birth-2yrs) | | | Early Childhood (2-4yrs) | | | Late Childhood (5-7yrs) | | | Latency (8-12yrs) | | Adolescents (13-17yrs) |
| Yes |  |  | | |  | | |  | | |  | |  |
| No |  |  | | |  | | |  | | |  | |  |
| **Cognitive Concerns**  Check all that apply | General Intellectual Abilities  Attention / Concentration  Academic Skills / Learning disabilities  Memory / Learning  Language / Communication  Visual Spatial Processing  Sensory Processing  Motor Functioning  Auditory / Phonological Processing  Social Cognition  Reasoning / Problem solving  Judgment / Decision making  Executive Processing (sequencing,  Other cognitive concerns  shifting between tasks, working memory, Describe:  processing speed, multi-tasking, etc.) | | | | | | | | | | | | | |
| **Other Concerns**  Check all that apply | Traumatic brain injury / concussion  Substance Abuse in pregnancy  Birth Injury  Autism characteristics  Anxiety  Moodiness / Emotional dysregulation  Depression  Obsessive or compulsive behaviors  Anger  Oppositionality / Defiance  Poor social skills / no friends  Sexual misbehavior  Other concerns- Describe: | | | | | | | | | | | | | |
| **Office Use** | Approved  Not within guidelines. Reason: Initials:  Insurance Confirmed | | | | | | | | | | | | | |