CHAMBERCARE

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:

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

Crisis Management

Educational Plan (if applicable)

Transition/Discharge Plan

Requesting Therapist:

Printed Name

Signature