UTAH DEPARTMENT OF HEALTH MEDICAID

ASD Diagnostic Confirmation Form

January 2018

Section 1- For children diagnosed prior to July 1, 2015 that were diagnosed without using the ADOS, ADOS-2, ADI-R or the PL-ADOS	
Member Name:	
Medicaid ID :	
Date of Autism Spectrum diagnosis:	
Name and credentials of diagnostic provider:	
Describe tools/process used for establishing diagnosis:	_____ _____
Diagnostic criteria met according to:	☐ Medical Records ☐ Current Examination
Check all that apply (all must be met):	☐ Deficits in social emotional reciprocity If present provide example: _____ _____ ☐ Deficits in non-verbal communicative behaviors related to social interaction If present provide example: _____ _____ ☐ Deficits in developing, maintaining, and understanding relationships If present provide example: _____ _____
Check all that apply (two must be met):	☐ Stereotyped or repetitive motor movements If present provide example: _____ _____ ☐ Insistence on sameness If present provide example: _____ _____ ☐ Highly restricted interests If present provide example: _____ _____ ☐ Hyper or Hypo reactivity to sensory input If present provide example: _____ _____
Check all that apply (all must be met):	☐ Symptoms were present in early development ☐ Symptoms cause significant impairments in daily functioning ☐ Symptoms are not better explained by intellectual disability
Choose one:	☐ Documentation from first diagnostic assessment enclosed ☐ No prior documentation available (must include explanation as to why records are not available): _____ _____

My examination of this patient confirms the previous diagnosis of Autism Spectrum Disorder.

_____ _____

Signature and Credentials of Certifying Provider Date

UTAH DEPARTMENT OF HEALTH MEDICAID

ASD Diagnostic Confirmation Form

January 2018

Section 2- Multidisciplinary diagnostic evaluation for children ages 2-6, diagnosed using a Level 2 ASD screening measure or evaluation tool.	
Member Name:	
Member ID:	
Date of Autism Spectrum diagnosis:	
Name and credentials of primary diagnostician:	
Explain in detail, the provider's advanced training and experience in the diagnostic evaluation of children with ASD:	_____ _____ _____ _____ _____
Name and credentials of audiology provider:	
Name and credentials of speech language provider:	
Name and credentials of other provider:	
Name and credentials of other provider:	
Describe tools/process used for establishing diagnosis:	_____ _____ _____
Was there a determination of the presence of DSM-5 criteria for ASD? (as described in section 1 of this document)	☐ Yes ☐ No

I, _____, hereby attest that the above information is true, accurate and complete to the best of my knowledge

_____ _____

Signature of Diagnostic Provider Date