OKLAHOMA
Health Care Authority

APPLIED BEHAVIOR ANALYSIS (ABA)

DISCHARGE FORM

ABA FACILITY INFORMATION	
ABA facility name:	
ABA facility address:	
Phone number:	
Treating BCBA name:	
Treating BCBA phone number:	
Treating BCBA email address:	

MEMBER INFORMATION	
Name:	
Date of birth:	
Address:	
Parent/guardian name and contact:	
Primary care physician:	

DISCHARGE DETAILS	
Start date of ABA:	
Reason for treatment (please provide a summary of the deficits or maladaptive behaviors treated):	
Diagnosis:	
Discharge date:	
Discharge summary (please provide the clinical rationale for discharge, i.e., member met goals, moved):	

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/OHCA
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

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FOLLOW-UP CARE
Treatment recommendations:
Follow up appointments:
Other care instructions:

PATIENT ACKNOWLEDGEMENT	
I, the undersigned, acknowledge that I have received and understand the information provided in this discharge form. I am aware of the follow-up appointments, recommendations, and care instructions.	
Patient name:	
Guardian name:	
Patient signature (if member is over 14 and can sign):	
Guardian signature:	
Date:	

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