Boston Children's Hospital | Autism Spectrum Center
Until every child is well

Welcome to the Autism Spectrum Center at Boston Children's Hospital

Thank you for your interest in the Autism Spectrum Center (ASC). We provide:

- Comprehensive, family-centered diagnostic and care services for children with autism spectrum disorder
- Initial appointment may be with **one** of the following providers:
  - Developmental Pediatrician
  - Neurologist
  - Nurse Practitioner
  - Psychologist
- Resource Specialists: dedicated staff who provide outreach and education

The below steps will need to be completed prior to adding your child to the waitlist:

1. **Complete and return all** attached forms to our office by mail, email or fax. **Please do not send your original forms. We encourage you to make copies of all information for your records.**

   Mail: Boston Children's Hospital
   Autism Spectrum Center BCH3433
   Attn.: Intake Coordinators
   300 Longwood Avenue
   Boston, MA 02115

   Email: AutismCenter@childrens.harvard.edu

   Fax: 617-730-4823

2. Please include copies of any recent documents from early intervention, school or outside providers such as:
   - **IFSP** (Individualized Family Service Plan-report from early intervention services)
   - **IEP** (Individualized Education Program)/**504 Accommodation Plan**
   - School district based **CORE/TEAM evaluations** (educational testing, psychological testing, OT, PT, and/or speech and language evaluations).
   - Any **private or clinic-based testing** (psychological testing, neuropsychological evaluation, OT, PT and/or speech and language evaluations).

3. Once all of this information has been received, **we will call to confirm and provide an estimate of your current wait time** for your initial visit.

The Autism Spectrum Center does not provide evaluations for child abuse and neglect, custody determination, immediate suicidality, IQ testing for gifted placement, or assessment for acute psychiatric conditions. If you need any of the above services, please let us know and we can direct you to an appropriate provider.

If you need further information or have any additional questions, please feel free to contact the Center by phone at 617-355-7493 or by email at AutismCenter@childrens.harvard.edu. You can also visit our website: www.bostonchildrens.org/autismspectrumcenter

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Family Education Sheet

Boston Children's Hospital
Autism Spectrum Center

childrenshospital.org/
autismspectrumcenter

Preparing for a Medical Appointment or Autism Spectrum Disorder (ASD) Evaluation

Whether you are coming to Boston Children's Hospital for an outpatient appointment, evaluation, a surgical procedure or an emergency visit, there are steps you can take to create a more positive experience for your child.

What should I bring?

Communication systems and devices

- **Bring your child's communication system or device** (for example: Dynavox, picture communication board, or iPad/tablet) to the appointment.
  - Even if your child can speak, the stress of a hospital visit can make it hard to communicate. Having these systems with you helps to make sure that your child can communicate with their medical team.

Distraction tools

Distraction items can help your child cope with a medical appointment.

- **Bring a favorite toy, sensory item, book or electronic device** (iPad or tablet)
- **Bring a set of headphones.** Headphones may be good for your child to wear if you are going to talk about sensitive issues with the health care provider.

Rewards or reinforcers

- **Bring items that you often use as rewards for your child in your home.** For example, if your child struggles with blood draws, it can be helpful to say "First blood draw, then a sticker."

Comfort items

If your child has favorite stuffed animal, blanket, or object, you can bring it. It may help to make the visit or stay more comfortable.

How can I prepare my child?

My Hospital Stories

- These are visual tools that give your child a sense of what may happen, what the hospital area may look like and what to expect.
- You can find My Hospital Stories here: http://www.childrenshospital.org/patient-resources/family-resources/child-life-specialists/preparing-your-child-and-family-for-a-visit/my-hospital-story.

Medication

Please give your child their medication as you normally would unless you are told otherwise by your provider's team.

Behavior support plan

- If your child often has a hard time with medical visits, you can **work with our team to develop a behavior support plan.** Call the Autism Spectrum Center at 617-355-7493 for help creating this plan.
- This plan will alert staff to your child's unique needs and preferences, including help with getting to a clinic, limiting the number of people in the room or providing distraction tools.

Child Life specialists

- Child Life Specialists use developmentally appropriate strategies and play to help support your child through medical procedures. The Autism Spectrum Center's Child Life Specialist can work with you to plan ahead for your visits, prepare for appointments and provide support on the day of the appointment.
- For more information, contact the Autism Spectrum Center's Child Life Specialist at 617-919-6390 or by e-mail at kristin.coffey@childrens.harvard.edu.

How can *I* prepare?

- Write down your questions and concerns **before** the visit to share with your child's provider.
- Give yourself more time than you think you need to get to the appointment.
- Ask for help if your child is having a difficult time—many departments or areas are able to offer accommodations.
- If possible, bring someone with you for support

This Family Education Sheet is available in Spanish.

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This Family Education Sheet is for educational purposes only. For specific medical advice, diagnoses and treatment, talk with your health care provider.

Insurance Information

Please fill out the below form with accurate information regarding your child's insurance plan(s). This information can be found on the insurance card, or by contacting your insurance company's member service number.

Most insurance companies require prior authorization for neuropsychological or psychological testing and/or mental health visits. Prior authorization is not a guarantee of payment coverage. Many insurers contract with a specific "carve-out" company to administer behavioral/mental health benefits and claims. If your insurer has such a "carve-out," the process for coverage determination and prior approval may be different from those processes used for your medical insurance benefits.

Please call your insurance company to inquire about coverage/benefits under your plan and your required out-of-pocket payments. Coverage policies for individual carriers differ greatly and change frequently.

Parent Name: ______________________________

Primary Insurance Carrier: ______________________________

Group name & number (if applicable): ______________________________

Patient name: ______________________________

Date of birth: ______________________________

Child's identification number: ______________________________

Effective from ____________________ to ____________________ (mm/dd/yyyy)

Subscriber's name & date of birth: ______________________________

Subscriber's address (if different than child's address): ______________________________

____

Important Member service phone number for mental health benefits (usually located on back of insurance card): ______________________________

Secondary Insurance Carrier (if applicable): ______________________________

Group name & number (if applicable): ______________________________

Patient name: ______________________________

Date of birth: ______________________________

Child's identification number: ______________________________

Effective from ____________________ to ____________________ (mm/dd/yyyy)

Subscriber's name & date of birth: ______________________________

Subscriber's address (if different than child's address): ______________________________

____

Important Member service phone number for mental health benefits (usually located on back of insurance card): ______________________________

Your signature below indicates that you have been advised that you may be responsible for paying all charges associated with the visit.

I acknowledge that is any of the above referenced items or services is not considered medically necessary by my insurance company or is a non-covered service, I am financially responsible for the full amount should the claim be denied. If I am denied insurance coverage for any service, discounts may be available.

Guarantor Name: ______________________________

Parent/Guarantor Signature: ______________________________ **Date:**__________

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A. GENERAL INFORMATION

(Child's Name): (*Last) ____________ (*First) ____________

(*Date of Birth) ____________ (*Gender) ☐M ☐F ☐Other

(*Person completing the questionnaire) ____________

URGENT CONCERNS

**** Please understand that the Autism Spectrum Center has a waiting list. Because some problems need more urgent attention if your child has any of the problems below, please also contact your pediatrician while you are waiting for your appointment.*

☐ Convulsions (Seizures)
☐ Loss of skills or words (regression)
☐ Loss of hearing
☐ Loss of vision
☐ Difficulty swallowing or choking
☐ Severe weakness or lack of coordination

SAFETY CONCERNS (risky behavior such as bolting, running in street) (please describe)

Please list the question(s) you would like answered by this evaluation (*at least one **REQUIRED**)

1. ____________
2. ____________
3. ____________

Who referred your child to the Autism Spectrum Center? (If a provider, please list name and specialty)	
Patient's Primary Care Provider (e.g. pediatrician, nurse practitioner)	
*What languages are spoken in the home?	
*Does you or your child require an interpreter for the visit?	☐ Yes ☐ No
*Has your child been involved with DCF?	☐ Yes ☐ No

B. CONTACT/DEMOGRAPHIC INFORMATION

***Parent/Caregiver 1 information**

Full Name: (Last) ____________ (First) ____________

Relationship to child: ____________

Home Street Address: ____________

City: ____________ State: ____________ Zip Code: ____________

Telephone (check preferred number) ☐ home ☐ work ☐ mobile

Email Address ____________

Occupation ____________

Are you a legal guardian of the child? ☐ Yes ☐ No Do you have physical custody of child? ☐ Yes ☐ No

Parent/Caregiver 2 information

Full Name: (Last) ____________ (First) ____________

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Relationship to child:

Home Street Address: ☐ check if same as above

City: State: Zip Code:

Telephone (check preferred number): ☐ home ☐ work ☐ mobile

Email Address:

Occupation:

Are you a legal guardian of the child? ☐ Yes ☐ No Do you have physical custody of child? ☐ Yes ☐ No

***Is there a custodial agreement in place for this child?** ☐ Yes ☐ No

Legal Guardian information (if different from above)

Full Name: (Last) (First)

Relationship to child:

Home Street Address:

City: State: Zip Code:

Telephone (check preferred number: ☐ home ☐ work ☐ mobile

Email Address:

Occupation:

Are you a legal guardian of the child? ☐ Yes ☐ No Do you have physical custody of child? ☐ Yes ☐ No

C. SERVICES CHECK if your child is receiving any of the following

☐ Early Intervention ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical therapy ☐ABA ☐Other _____________

****Please submit copies of the most recent Individualized Family Service Plan (IFSP)**

D. CONCERNS YOU HAVE ABOUT YOUR CHILD'S DEVELOPMENT OR BEHAVIORS

*Please check **any concerns you have** about your child

☐ Autism Spectrum Disorder	☐ Behavior problems (Prolonged tantrums/aggression)	☐ Rigidity or problems with transitions
☐ Attention problems	☐ Lack of pretend play	☐ Limited pointing/use of gestures
☐ Social skills delay	☐ Reduced eye contact	☐ Sensory sensitivities
☐ Speech/language delay	☐ Repetitive motor behaviors (flapping/rocking)	☐ Sleep
☐ Fine motor delay	☐ Intense interests	☐ Eating and Feeding
☐ Gross motor delay		☐ Self-injurious behavior
☐ Epilepsy/seizures		

Has your child been evaluated for autism spectrum disorder before? YES/NO

If yes, where ____ (please attach evaluation)

E. CHILD'S MEDICAL HISTORY

☐ Check if child's entire medical history is unknown – and answer as you are able.

Please check any conditions your child has been **DIAGNOSED** with:

Neurological Problems:	**Developmental Disorders**
☐ Epilepsy/seizures	☐ Autism
☐ Cerebral Palsy	☐ Global Developmental Delay
☐ Hearing problems	☐ Speech and Language Delay
☐ Head injury	☐ Motor Delay

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General Medical Problems: **Does your child have ongoing medical concerns – please list.** 1. 2. 3. 4. **Surgical History:**	**Please list any medications (prescription and over the counter) your child takes** 1. 2. 3. 4. 5.

Has the child ever had any of the following screening/diagnostic tests or procedures?		**If yes, when, where, and results? (Please send in copies of results if available)**
Genetic and/or metabolic testing	☐ Yes ☐ No ☐Don't know	
EEG	☐ Yes ☐ No ☐Don't know	
CT scan or MRI of the head	☐ Yes ☐ No ☐Don't know	
Sleep study	☐ Yes ☐ No ☐Don't know	
Hearing test	☐ Yes ☐ No ☐Don't know	
Vision test	☐ Yes ☐ No ☐Don't know	

F. CHILD'S BIRTH HISTORY

☐ Check if birth history is unknown

Age of mother at delivery: ____________________

Age of father at delivery: ____________________

Number of previous pregnancies (including miscarriages or terminations) ____________________

During pregnancy, did the mother:

Take prenatal vitamins	☐ Yes ☐ No	
Use tobacco	☐ Yes ☐ No	If yes: how much?
Drink alcohol	☐ Yes ☐ No	If yes: how much?
Take drugs or medications	☐ Yes ☐ No	If yes: what drug(s) or medication(s), and during which trimester(s):

Birth Measurements	Weight: Height: Head Circumference:
Was the baby born at term?	☐ Yes ☐ No If no,numbers of weeks gestation at birth:
What was the delivery method? *If cesarean, please describe why*	☐ vaginal ☐ cesarean (C-section)
Were there any prenatal or neonatal complications? *If yes, please describe:*	☐ Yes ☐ No
Was a NICU or extended hospital stay required? *If yes, please describe:*	☐ Yes ☐ No

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G. CHILD'S DEVELOPMENTAL HISTORY

As best as you can remember, list the age or check off the approximate time at which your child reached the following developmental milestones.

☐ **Check if you are not able to recall or the child was not in your care**

Developmental Skill	Age (if known)	Not yet	*Only if exact age cannot be recalled*		
			Early	At Normal Time	Late
Sat without support		☐	☐	☐	☐
Crawled		☐	☐	☐	☐
Stood without support		☐	☐	☐	☐
Walked without assistance		☐	☐	☐	☐
Spoke first words		☐	☐	☐	☐
Said phrases		☐	☐	☐	☐
Said sentences		☐	☐	☐	☐

Please summarize your child's OVERALL FUNCTIONING (i.e., emotionally, behaviorally, socially, etc.) by choosing ONE number below.
Please circle only one number.

1	**Excellent** functioning/No impairment in settings
2	**Good** functioning/Rarely shows impairment in settings
3	**Mild** difficulty in functioning/Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning/Usually shows impairment in settings
5	**Severe** difficulties in functioning/Most of the time show impairment in settings

****Please submit copies Individualized Family Service Plan (IFSP).**

PLEASE FEEL FREE TO DESCRIBE ANY ADDITIONAL INFORMATION WE SHOULD KNOW ABOUT YOUR CHILD; AND ATTACH ANY ADDITIONAL DOCUMENTS YOU WOULD LIKE TO SHARE:

*Parent/Guardian Signature

*Print Name

*Date

*Relationship to patient

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Early Childhood Educational Questionnaire

Child's Name: *Last ______________________ *First ______________________

*Date of Birth: ______________________ *Gender: ☐M ☐F ☐Other

Child' classroom/age level: ______________________

Please have early intervention, child care and/or school personnel fill out and return.

Mail: Boston Children's Hospital, Autism Spectrum Center BCH3443, 300 Longwood Ave., Boston, MA 02115

Email: AutismCenter@childrens.harvard.edu Fax: 617-730-4823

EI Program/Child Care/School: ______________________

EI/Child Care/School address: ______________________

Form completed by: ______________________ Position: ______________________

With help from: ______________________

Contact Person: ______________________

Phone number and best time to call: ______________________

Email address ______________________

List up to 3 specific questions you would like answered as a result of this evaluation that would help you better meet this child's developmental and educational needs.

1. ______________________
2. ______________________
3. ______________________

In your opinion, what areas of this child's functioning need the most improvement?

Please describe this child's strengths.

Please describe any other concerns you have about this child.

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Besides English, are there any additional languages used for this child's instruction? ☐ Y ☐ N

If yes, what language? ____________________

ACADEMIC READINESS: Please check the appropriate column

	Not Yet	Progressing	Proficient
A. Basic Concepts			
1. Knows colors	☐	☐	☐
2. Knows letters of alphabet	☐	☐	☐
3. Knows numbers and counts past 10	☐	☐	☐
4. Adds and subtracts things	☐	☐	☐
5. Size concepts	☐	☐	☐
6. Location concepts	☐	☐	☐
B. Language and Communication			
1. Uses speech to communicate	☐	☐	☐
2. Explains and describes things	☐	☐	☐
3. Rhymes words and remembers poems/songs	☐	☐	☐
4. Uses uncommon words	☐	☐	☐
5. Uses long sentences	☐	☐	☐
6. Tells or retells stories or events	☐	☐	☐
7. Speaks understandably	☐	☐	☐
8. Follows oral instructions on level with peers	☐	☐	☐
9. Uses correct grammar (e.g. verb tense)	☐	☐	☐
10. Uses sign language or other communication system	☐	☐	☐
11. Follows classroom routine	☐	☐	☐
C. Emergent Literacy			
1. Listens to stories in books	☐	☐	☐
2. Asks questions about words	☐	☐	☐
3. Reads words on signs and labels	☐	☐	☐
4. Reads words in books	☐	☐	☐
5. Recites books from memory	☐	☐	☐
6. Reads "easy" books	☐	☐	☐
7. Writes or copies words	☐	☐	☐
8. Dictates stories	☐	☐	☐
9. Writes "little" stories	☐	☐	☐
10. Answers questions about orally read story	☐	☐	☐
D. Motor Skills			
1. Constructs puzzles or builds things	☐	☐	☐
2. Uses pencils and pens correctly	☐	☐	☐
3. Uses scissors well	☐	☐	☐
4. Copies and traces shapes	☐	☐	☐
5. Draws recognizable objects	☐	☐	☐
6. Is coordinated in outdoor recess activities	☐	☐	☐
7. Ties shoe laces	☐	☐	☐

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EARLY CHILDHOOD SCREENING ASSESSMENT:

Please check the column that best describes this child compared to other children the same age. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
1. Seems sad, cries a lot	☐	☐	☐	☐
2. Is difficult to comfort when hurt or distressed	☐	☐	☐	☐
3. Loses temper too much	☐	☐	☐	☐
4. Avoids situations that remind him/her of scary events	☐	☐	☐	☐
5. Is easily distracted	☐	☐	☐	☐
6. Hurts others on purpose (e.g., biting, hitting, kicking)	☐	☐	☐	☐
7. Doesn't seem to listen to adults talking to him/her	☐	☐	☐	☐
8. Battles over food and eating	☐	☐	☐	☐
9. Is irritable, easily annoyed	☐	☐	☐	☐
10. Argues with adults	☐	☐	☐	☐
11. Breaks things during tantrums	☐	☐	☐	☐
12. Is easily startled or scared	☐	☐	☐	☐
13. Tries to annoy people	☐	☐	☐	☐
14. Has trouble interacting with other children	☐	☐	☐	☐
15. Fidgets, can't sit quietly	☐	☐	☐	☐
16. Is clingy, doesn't want to separate from parent	☐	☐	☐	☐
17. Is very scared of certain things (e.g., needles, insects)	☐	☐	☐	☐
18. Seems nervous or worries a lot	☐	☐	☐	☐
19. Blames other people for mistakes	☐	☐	☐	☐
20. Sometimes freezes or looks very still when scared	☐	☐	☐	☐
21. Avoids foods with specific textures or tastes	☐	☐	☐	☐
22. Is too interested in sexual play or body parts	☐	☐	☐	☐
23. Runs around in settings when should sit still	☐	☐	☐	☐
24. Has a hard time paying attention to tasks or activities	☐	☐	☐	☐
25. Interrupts frequently	☐	☐	☐	☐
26. Is always "on the go"	☐	☐	☐	☐
27. Reacts too emotionally to small things	☐	☐	☐	☐
28. Is very disobedient	☐	☐	☐	☐
29. Has more picky eating than usual	☐	☐	☐	☐
30. Has unusual repetitive behaviors (e.g., rocking, flapping)	☐	☐	☐	☐
31. Might wander off if not supervised	☐	☐	☐	☐
32. Has a hard time falling asleep or staying asleep	☐	☐	☐	☐
33. Doesn't seem to have much fun	☐	☐	☐	☐
34. Is too friendly with strangers	☐	☐	☐	☐
35. Has more trouble talking or learning to talk than others	☐	☐	☐	☐
36. Is learning or developing more slowly than other children	☐	☐	☐	☐
Are you concerned about this child's emotional or behavioral development (please only circle one)?	☐ Yes	☐ Somewhat	☐ No	

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Please summarize this child's OVERALL FUNCTIONING (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE option below. Compare this child's functioning in child care/school and with peers to "average children" his/her age that you are familiar with from your experience.
Please circle only one number.

☐	**Excellent** functioning/No impairment in settings
☐	**Good** functioning /Rarely shows impairment in settings
☐	**Mild** difficulty in functioning/Sometimes shows impairment in settings
☐	**Moderate** difficulty in functioning/Usually shows impairment in settings
☐	**Severe** difficulties in functioning/Most of the time shows impairment in settings
☐	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
☐	**Needs 24-hour professional care and supervision** due to severe behavior or gross impairment(s)

Please describe this child's social-emotional functioning, including moods and relationship with peers.

Please describe this child's behavior.

Is there any other information you think would be helpful for evaluating this child?

*EI Specialist/Teacher Signature *Print Name *Date

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