Team Meeting Date_____ **ASD Team SITE**_____ **Child's Name**_____

ASD Team Data Form

Complete this form for each child seen by the ASD team.

Date referred to ASD Team: _____ (dd/mm/yy)

I. CONTACT INFORMATION

A) Child's:

First Name: _____ Middle I: ____

Last Name: _____

Date of Birth: __ / __ / ____

Gender: ❑ M ❑ F

B) Parent/Guardian:

Name: _____

Phone: (____) ____ - _____

Address: _____ City: _____

Zip: _____ __ County _____

E-mail: _____

II. DEMOGRAPHICS OF CHILD

A) Race (check only one)

❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Asian

❑ Native Hawaiian or Pacific Islander ❑ Two or more races ❑ Unknown

B) Ethnicity (check only one)

❑ Hispanic ❑ Non-Hispanic ❑ Unknown

C) Preferred Language: Spoken: _____ Written: _____

III. HEALTH COVERAGE FOR CHILD

A) Does this child have a *Primary Care Provider*? (check only one) ❑ Yes ❑ No ❑ Unknown

If yes, please identify: _____

B) Does this child have *Insurance*? ❑ Yes ❑ No ❑ Unknown

If yes, indicate Primary Insurance Type (ONE per child):

❑ OHP Standard ❑ OHP Plus ❑ CAWEM ❑ Indian Health Services

❑ Private (please specify) _____ ❑ Unknown

IV. ASD TEAM

A) Professionals that participated in ASD identification process: Circle the number of professionals that participated in the ASD identification process.

Professionals	Number Present				Professionals	Number Present			
Physician	1	2	3	4	Occupational Therapist	1	2	3	4
Clinical Psychologist	1	2	3	4	Physical Therapist	1	2	3	4
School Psychologist	1	2	3	4	ASD Specialist	1	2	3	4
Psychiatric Nurse Practitioner	1	2	3	4	Other: _____				
Speech Therapist	1	2	3	4					

B) Professionals present during ASD determination meeting. Circle the number of professionals present.

Professionals	Number Present				Professionals	Number Present			
Physician	1	2	3	4	ASD Specialist	1	2	3	4
Clinical Psychologist	1	2	3	4	Teacher/School Representative	1	2	3	4
School Psychologist	1	2	3	4	CaCoon Nurse	1	2	3	4
Psychiatric Nurse Practitioner	1	2	3	4	Family Liaison	1	2	3	4
Speech Therapist	1	2	3	4	Interpreter	1	2	3	4
Occupational Therapist	1	2	3	4	Other: _____				
Physical Therapist	1	2	3	4					

C) ASD Identification. Did the team make an identification of ASD for this child?

- ❑ Yes
- ❑ No
- ❑ Unsure

If No, please describe areas of disagreement:_____

_____

_____

_____

_____

_____

_____

D) Co-Occurring or co Morbid Conditions:

- ❑ ADHD
- ❑ Seizure Disorders
- ❑ Gastrointestinal Disorders
  - ❑ Constipation and/or Diarrhea
  - ❑ Inflammatory Bowel Diseases
  - ❑ Eosinophilic Gastrointestinal Disorders
  - ❑ (EGIDs)
  - ❑ Celiac Disease
- ❑ Mitochondrial Diseases
- ❑ Inborn Errors of Metabolism
- ❑ Tuberous Sclerosis
- ❑ Fragile X Syndrome
- ❑ Primary Immunodeficiency Disease
- ❑ Anxiety Disorder
- ❑ Hypothyroidism
- ❑ Food and Environmental Allergies
- ❑ Feeding Issues
- ❑ Sleep disorders
- ❑ Obsessive Compulsive Disorder
- ❑ Mood Disorder
- ❑ Sensory Processing Disorder
- ❑ Apraxia
- ❑ Tourette Syndrome
- ❑ Depression
- ❑ Dyspraxia
- ❑ Rett Syndrome
- ❑ Central Auditory Processing Disorder
- ❑ Dyslexia
- ❑ Hyperlexia

E) Services:

Early Intervention

- ❑ Autism
- ❑ Developmental Delay
- ❑ Physical or Mental Condition
- ❑ Vision Impairment
- ❑ Hearing Impairment
- ❑ Orthopedic Impairment
- ❑ Deaf Blind
- ❑ Traumatic Brain Injury

Early Childhood Special Education

- ❑ Autism
- ❑ Developmental delay
- ❑ Intellectual Disability
- ❑ Vision impairment
- ❑ Hearing Impairment
- ❑ Communication
- ❑ Orthopedic impairment
- ❑ Specific learning disability
- ❑ Emotional disturbance
- ❑ Deaf-blind
- ❑ Traumatic brain injury
- ❑ Other health impairment

Health Services Referred to:

Does this child need to be referred to CDRC for further evaluation because the local team is unsure about ASD Identification: Yes ❑ No ❑ **If yes**, which location: ❑ Eugene ❑ Portland

Or other center-based team_____ (insert name) for further evaluation.

Other Issues and Referrals:

_____
_____
_____
_____
_____