ASD Team Evaluation Summary

To: Family_____**and**

To: Primary Care Provider _____

Child's name:_____**D.O.B.**_____was referred by _____

to the_____(insert team) Autism Identification Team.

This child was evaluated on_____(date) for an autism spectrum disorder (ASD).

The following team members participated in the ASD identification process:

Name (please print)	Title	Signature

The ASD team ❑ **did /** ❑ **did not** (check one) make an identification of ASD for this child.

The ASD team ❑ **does /** ❑ **does not** (check one) recommend a referral to_____for further evaluation regarding a possible ASD.

The ASD team ❑ **did /** ❑ **did not** (check one) identify another condition:

- ❑ Expressive language disorder
- ❑ Vision Impairment
- ❑ Mixed receptive and expressive language disorder
- ❑ Hearing Impairment
- ❑ Developmental delay
- ❑ ADHD (at risk for ADHD due to the child's age)
- ❑ Attachment disorder
- ❑ Anxiety disorder
- ❑ Other

The following assessments were done:

- ❑ **DSM Interview**
  Criteria Met: ❑YES / ❑No Notes: _____
- ❑ **STAT**
  Score _____ Notes: _____
- ❑ **DSM Checklist:**
  Criteria Met: ❑YES / ❑NO Notes: _____
- ❑ **Physical Exam**
  Notes (presence of minor/major anomalies, other important findings:
  _____
  _____
- ❑ **ADOS-2**
  Overall Rating: _____ Notes: _____
- ❑ **Communication**
  Language Level:_____Notes: _____
- ❑ **Cognitive**
  Test/Scores:_____Notes: _____
- ❑ **Developmental Delay**
  Test/Scores:_____Notes: _____
- ❑ **ABAS-2**
  Score:_____Notes: _____

❑ **Other:**

Notes: _____

The child ❑ **is /** ❑ **is not** (check one) eligible for Early Intervention or Early Childhood Special Education services.

If eligible, s/he qualifies under the following eligibility category:

- ❑ Autism
- ❑ Hearing Impairment
- ❑ Developmental Delay
- ❑ Orthopedic Impairment
- ❑ Intellectual Disability
- ❑ Deaf-Blind
- ❑ Vision Impairment
- ❑ Traumatic Brain Injury
- ❑ Specific learning disability
- ❑ Emotional disturbance
- ❑ Communication
- ❑ Other health impairment

The ASD Team recommended the family contact:

- ❑ Social Security Income (SSI)
- ❑ Oregon Developmental Disabilities
- ❑ CaCoon home-visiting nurse care coordination services (public health)
- ❑ Autism Society of Oregon
- ❑ Autism Speaks
- ❑ Other: _____

The team has the following recommendations for the child's primary care provider:

- ❑ Specialty referral: _____
- ❑ Medical Test/Procedure: _____
- ❑ Other: _____

Notes:

_____

_____

Signature:

Autism Identification Team Physician_____(signature)

Contact information:

Team Physician:_____Phone _____

Email: _____

Your ASD ID Parent Partner is:_____ (name)

Email:_____ Phone _____

For more information about the ASD ID team or to make a referral, please contact the local site coordinator:

_____ (name)

Phone Number:_____Email: _____

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