**School Medical Autism Review Team Demographics Form**

**Date of referral: \_\_/\_\_/\_\_\_\_ Person Referring: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_/\_\_/\_\_\_\_**

**Parent/Guardian(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_**

**Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School/Daycare/Birth to three: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Occupational Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Speech Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Medical Autism Review Team (SMART) Authorization for Release of Records**

**Purpose:** As parent/guardian, you have the right to give or not to give permission for the release of your child’s records to other persons or agencies. By signing this authorization you are giving permission to exchange confidential information for Autism Spectrum Disorder screening purposes.

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_/\_\_/\_\_\_\_**

I hereby authorize the exchange of information orally, in writing or electronically between the School Medical Autism Review Team (SMART) and the agencies/persons listed below:

|  |
| --- |
| Primary Care Provider: |
| Early Intervention Provider: |
| Daycare: |
| Therapist: |
| School District: |
| Other: |
| Other: |
| Other: |

**The records to be exchanged include:**

Medical/Health History information

Evaluation/Assessment results

Developmental information

Educational Reports (Progress/IEP/504/IFSP)

**This authorization is valid from \_\_/\_\_/\_\_\_\_ to \_\_/\_\_/\_\_\_\_. If not specified, this authorization is valid for one year from date signed.**

I understand that the information obtained will be treated in a confidential manner and I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under prior consent release.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Patient Signature (if patient is 13 years of age or older)

**School Medical Autism Review Team (SMART) Tool**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_/\_\_/\_\_\_\_

Today’s Date: \_\_/\_\_/\_\_\_\_

Name of person filling out form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Social Communication and Interaction | True | False |
| Impairments in the use of eye contact during social interactions. Example: *Child* *looks to the side or at your mouth rather than your eyes when speaking to you.* |  |  |
| Deficits in the use of facial expressions to communicate. Example: *Child doesn’t frown, pout, look surprised.* |  |  |
| Lack or reduced use of gestures to communicate. Example: *Child doesn’t wave bye, nod yes or no, blow a kiss.* |  |  |
| Impairments in back and forth conversation (appropriate to language level). Example: *Child won’t add something new or ask a question in response to a comment made to them.* |  |  |
| Lack of, reduced, or impaired responses to social initiations of others  Example: *Child doesn’t respond to his or her name or acknowledge others.* |  |  |
| Lack of, or reduced interest in peers ( appropriate to developmental level) |  |  |
| Lack of, reduced, or impaired initiations of interaction with others |  |  |
| Reduced preference for some peers over others/impaired friendships |  |  |
| Delays in, or lack of, varied, age appropriate play with peers |  |  |

|  |  |  |
| --- | --- | --- |
| Restrictive, Repetitive Patterns of Behavior, Interest and Activities | True | False |
| Has typical speech characteristics (echoing, jargon, unusual rhythm or volume) |  |  |
| Has repetitive body mannerisms |  |  |
| Reacts negatively to changes in schedule/insists on sameness |  |  |
| Has behavioral rituals |  |  |
| Has verbal rituals ( must say things, or have others say things in a particular way) |  |  |
| Has specific interests that are unusual in intensity (hobby of unusual intensity) |  |  |
| Engages in a limited range of activities |  |  |
| Has a limited behavioral repertoire |  |  |
| Shows hyper reactivity to sensory input |  |  |
| Shows hypo reactivity to sensory input |  |  |
| Shows unusual sensory interest and preferences |  |  |

|  |  |  |
| --- | --- | --- |
| Disruptive Behavior | True | False |
| Engages in aggressive and/or destructive behaviors toward self, others or objects (self-injury, elopement, property destruction) |  |  |

**Please leave comments on the backside of this page. Make copies if needed**



**Dear Parent or Guardian,**

Your child has been referred to the School Medical Autism Review Team due to concerns of possible Autism Spectrum Disorder (ASD). Enclosed is a packet of information and forms that are needed to further address this issue. Please read this material and follow all instructions so we can be of outmost help to you and your child.

**Patients needing a first evaluation for possible ASD will need the following:**

Our ASD screening process consists of gathering all relevant information concerning your child’s medical, academic, family, and social history.

1. Parents/caregivers, please complete and return to our office the following forms (enclosed)
   1. Authorization of Release of Records
   2. SMART demographics form
   3. SMART tool
2. Give a SMART tool to anyone familiar with your child such as current teacher, SLP, OT and/or Daycare provider.
   1. It is your responsibility to ensure the school /providers return these forms to you prior to submitting the package for the SMART to review.
3. Provide our office with copies ( no originals please) of:
   1. Report cards –past 2 years
   2. Reports of any testing done by school psychologist, occupational, language or physical therapists, child find, developmental screening or school district required testing.
   3. Copies of 504 plan, IFSP or IEPs if applicable
   4. Reports of any previous evaluations by physicians, psychologists or psychiatrists.

Ask the school for copies of needed

**Please bring the completed packet to Oakland Bay Pediatrics, 247 Professional Way, Shelton, WA 98584. If other arrangements need to be made please call 360-426-3102. Upon receipt of info, our team will assess the data**

**School Medical Autism Review Team Packet Checklist**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_/\_\_/\_\_\_\_

Primary Care Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Packet Forms:

* Authorization form for release of records
* Demographics information
* SMART tools filled out by:
  + Parent
  + Gen Ed teacher
  + Special Ed teacher
  + Speech and language pathologist
  + Occupational therapist/Physical therapist
  + School psychologist
  + Daycare provider
  + Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information:

* Report cards past 2 years
* Reports of any testing done by school psychologists, occupational, language or physical therapists including any developmental screenings.
* Copies of 504 plans or IEPs or IFSPs
* Reports of previous evaluations by physicians, psychologists or psychiatrists.