Pacific and Grays Harbor Counties SMART Team

Dear Parent or Guardian,

Your child has been referred to the School Medical Autism Review Team (SMART) because there are concerns about your child's behavior or development. The SMART team consists of community service providers who have the experience and passion for supporting local families. The SMART team will make recommendations or referrals to a certified Center of Excellence (COE) Provider who is able to evaluate and provide a diagnosis if one is warranted.

Enclosed in this packet you will find information and forms that are required to begin this process which include medical, academic, and social history. **This confidential paperwork is vital for us to gain an accurate picture of your child and will support the SMART Team in determining if your child is eligible to be referred for an evaluation.** We thank you for entrusting us with this delicate and valuable information in order to improve your child's welfare. Because the members of the SMART program are considered mandated reporters, if we have good reason to believe that a child is being abused or neglected, we must inform Child Protective Services.

Patients needing a first evaluation for possible Autism Spectrum Disorder (ASD) will need the following:

Our ASD screening process consists of gathering all information concerning your child's medical, academic, family, and social history. The next page is a checklist of all of the information that we will need. Please go through the checklist thoroughly. Deliver all documents, notes and summaries about your child to the SMART Coordinator in your county listed below. You can mail, hand deliver, or fax documents. (No originals please.)

Grays Harbor County Public Health
Stefani Joesten – SMART Coordinator

Office: 360.500.4350
Work Cell: 360.660.5024
Fax: 360.533.6272

Mailing Address:
2109 Sumner Ave
Aberdeen, WA 98520

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School Medical Autism Review Team Forms Checklist

Child's Name: _____ Date of Birth: _____

Please include the following forms and records when you return your packet: *It is your responsibility to ensure the school /providers return these forms **to you** prior to submitting the documents for the SMART Team to review in a timely manner.*

- □ **Demographics Form**
- □ **Getting To Know…** This form should be filled out by *the people who are with your child and see their behaviors regularly.*
    - Parent/Guardian
    - Child Self-report (older child)
    - Relative
    - General Education teacher
    - Special Education teacher
    - Speech and language pathologist
    - Occupational therapist/Physical therapist
    - Health Care provider (doctor)
    - Mental Health provider/Counselor
    - School psychologist
    - Child Care provider
    - Early Childhood Intervention program

    Additional Information: *There is a notes section on this form that is a good space for you to include more information about your child's strengths and challenges. Any information and detail you can provide will be helpful. Remember, you are the expert on your child.*
- □ **Release of Information** – if you are unable to get these records we will try to help by contacting providers listed on this form
- □ Screenings/Assessment – Ages and Stages Questionnaire, MCHAT, DIAL
- □ School report card or progress report
- □ 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, Functional Behavioral Analysis (FBA), Behavioral Intervention Plan (BIP) (no originals please)
- □ Copies of previous evaluations by physicians, psychologists or psychiatrists.

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Demographics Form

Date: _____ Referred by: _____

Child's Name: _____DOB:_____

Primary Language: _____Translator Needed?: Y N

Parent/Guardian 1 :_____ Relationship to Child:_____

Primary Phone: _____ Text ok? Y N

Parent/Guardian 2 :_____ Relationship to Child:_____

Primary Phone: _____Text ok? Y N

Mailing Address: _____

City: _____State:_____ Zip:_____

Insurance Provider:_____

Please provide the name and contact information for the following (if applicable):

Primary Medical Provider/Clinic: _____

School/Teacher: _____

Childcare Provider: _____

Early Childhood Program: _____

Occupational/Physical Therapist: _____

Speech Therapist: _____

Mental/Behavioral Health: _____

WISE Team: _____

DCYF Case Worker:_____

Other: _____

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RELEASE OF INFORMATION

General Release Related to Medical, Educational and Developmental Care

I give my consent for the mutual exchange of information relating to my child's health, development, medical coverage, and services provided with members of the Pacific and Grays Harbor Counties School and Medical Autism Review Team. I authorize the facilities below to release all medical records, which may include alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment. Please include any testing results. I authorize the school or school districts below to release all educational records, which may include special education plans or evaluations.

Agency Name	Contact Information
Primary Care Doctor	
Specialist	
School District	
School	
Other	
Other	
Other	

Child's Name: _____DOB:_____

I understand that health care information, STD and HIV/AIDS information, and mental health information relating to me is protected by state law and cannot be disclosed to anyone else without my written consent unless permitted by law. (Title 42 of the Federal Register)

I understand that I may cancel this consent at any time. This authorization expires one year after the last date it was signed. It can be renewed. A copy of this document may be considered the same as the original.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

Pacific and Grays Harbor Counties SMART Team

Getting To Know…

Child's Name: _____Date of Birth: _____

Today's Date: _____

Name of person filling out form:_____Relationship to Child: _____

This child has been referred to the SMART Team for behavioral and developmental assessment**. This form is for any service providers, family members, or others in close contact with the child named on this form.** Please fill out the form in its entirety to the best of your ability.

Social Communication & Interaction	True	False
Looks you in the eye for more than a second or two.	☐	☐
Uses facial expressions to communicate. *Example: Smiles at you when you smile.*	☐	☐
Uses gestures to communicate. *Example: Waves goodbye, nods yes or no, blows a kiss, points with pointer finger.*	☐	☐
Interacts in back and forth conversation (appropriate to language level). *Example: Asks a question in response to a comment made to them, shares interests.*	☐	☐
Responds to social initiations of others. *Example: Responds to his/her name or acknowledges others.*	☐	☐
Shows interest in other children (appropriate to developmental level). *Example: Watches other children, smiles at them, goes to them.*	☐	☐
Initiates interaction with others. *Example: Says "hello" or begins conversations.*	☐	☐
Makes friends easily.	☐	☐
Engages in age appropriate play with peers. *Example: Plays pretend or games.*	☐	☐
Engages in aggressive and/or destructive behaviors toward self, others or objects. *Example: Self-injury, running away or property destruction.*	☐	☐

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Restricted, repetitive patterns of behavior, interests & activities	True	False
Has unusual speech patterns. *Example: Echoing, jargon, unusual rhythm or volume.*	☐	☐
Has repetitive body mannerisms. *Example: Hand flapping.*	☐	☐
Has stereotypes use of objects. *Example: Lining up toys or flipping objects.*	☐	☐
Reacts negatively to changes in schedule or insists on sameness. *Example: Extreme distress at small changes, difficulties with transitions.*	☐	☐
Has behavioral rituals. *Example: Need to take the same route or eat the same food every day.*	☐	☐
Has verbal rituals. *Example: Must say things, or have others say things, in a particular way.*	☐	☐
Has specific interests that are unusual in intensity. *Example: Strong attachment to unusual objects, knows detailed information about one interest.*	☐	☐
Engages in a limited range of activities. Has a limited behavioral repertoire.	☐	☐
Shows hyper-reactivity to sensory input. *Example: Adverse response to specific sounds, textures or foods. Excessive smelling or touching of objects.*	☐	☐
Shows hypo-reactivity to sensory input. *Example: No reaction to pain or temperature.*	☐	☐
Shows unusual sensory interests and preferences. *Example: Visual fascination with lights or movement.*	☐	☐

Please provide more information about any additional concerns you may have about the child in the space below. Use additional page if necessary.