Case Presentation form

San Juan County Autism Collaborative (SJCAC)

Case Presentation Form

Complete this form to the best of your ability. This survey is individualized and should only be completed and submitted by the listed provider.

Email Kristen Rezabek at [kristenr@sanjuanco.com](mailto:kristenr@sanjuanco.com) if you have any questions or comments.

Presenting Provider Name:

Clinic/Facility Name & City:

Provider Phone Number:

Provider Email Address:

Presentation date:

Presentation Type:  New  Follow Up

**The following information will be specific to the patient you are presenting today.**

**Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If sharing outside of SJCAC SMART please do not include any specific patient health information such as: patient’s name or where they live, name of daycare/school/ program they attend, and avoid specific names of clinics, hospitals, or clinicians**

Biological Gender:  Male  Female

Patient Age:

(Years)

(months)

How long has the child been in your care?

Insurance: None

Medicaid Medicare Private



Insurance Company:

Race: Multi-racial

White/Caucasian



Native Hawaiian/Pacific Islander Black/African American

Asian

American Indian/Alaskan Native Prefer not to say

Other

If other, please specify race:

Ethnicity: Hispanic/Latino

Not Hispanic/Latino Prefer not to say



**Primary Concern?**

The concern you are presenting today is it a:

Question of autism

Management for symptoms related to autism.

Do parents share your concern?  Yes  No

Please list your primary concern(s) that you wish to discuss today:

Does this child have an autism diagnosis?  Yes  No

If Yes, age at diagnosis:

((Yrs))

Who made diagnosis:

What are the primary obstacles getting in the way of this patient's learning?

Language/Communication Behavior

Rigidity Social Sensory Motivation

Attention/Focus Anxiety

Other medical (e.g seizures, GI, sleep) Other (write in)

Please describe the obstacles:

**BIRTH HISTORY**

Were there complications during pregnancy?  Yes  No

(i.e. bed rest, hypertension, etc)

Please describe the pregnancy complications:

Any prenatal exposures to alcohol, drugs, tobacco or any other medications:  Yes  No

Please list exposures (i.e. alcohol, drugs, tobacco, medications):

Birth information: Select all that are true. If there are complications or prematurity you will be prompted for details.

Full term

Preterm- less than 37 weeks Normal vaginal delivery

C-Section

Delivery complications

Normal birth weight, length, head circumference Abnormal birth weight, length and or head circumference Other

You indicated that the patient was preterm, less than 37 weeks. What was their gestational age in "weeks+days" at birth?

You indicated that there were delivery complications. Please describe:

You indicated there were abnormal birth weight, height or head circumference. Please described:

You indicated that there was concern about the birth. Please describe:

Neonatal period:

unremarkable

concerns present during neonatal period such as NICU stay, feeding challenges, seizures, etc.

You indicated there were concerns present during the neonatal period. Please briefly describe:

**HEALTH HISTORY**

Any history of hospitalizations, surgeries, significant illnesses or injuries: (if you select yes, you will be asked to describe)

 Yes  No

You indicated that your patient has been hospitalized or had a significant illness or injury. Please briefly describe:

Prior medical evaluations and diagnostic studies:

None

Hearing evaluation Vision evaluation

Speech and Language evaluation Occupational therapy evaluation Physical therapy evaluation

Seen by a medical specialist (neurology, cardiology, etc)

Genetic testing (microarray, fragile X) MRI (brain, spine)

EEG

Sleep study Lead level other

Hearing Test Results:

Vision Results:

Results of the speech, occupational and/or physical therapy evaluations:

You indicated that they have seen a medical specialist. Please briefly describe who, when, and the outcome.

You indicated there were other evaluations. Please describe:

Genetic Results:

MRI Results:

EEG Results:

Sleep Study Results:

Lead Level Results:

Other Results:

Prior psychiatric evaluations:

None

Mental Health evaluation Evaluation for autism Evaluation for ADHD

Evaluation for anxiety (or other mood disorder)

Followed by a psychiatric provider other

You indicated that there has been prior mental health or psychiatric evaluation. Please describe the results

including diagnoses and who made that diagnosis:

Is your patient currently taking any medications, herbs or supplements?  Yes  No

Please list the medications, herbs and supplements they are taking:

Any known allergies to medications or other significant allergies?  Yes  No

Please list the medication or other allergies:

**FAMILY HISTORY:**

**Please indicate if there is any known family history below.**

Mom Dad Brother Sister Mat GM Mat GF Pat GM Pat GF

Genetic Disorders

Autism Spectrum Disorder Intellectual Disability Learning Disability

Seizure Disorder (e.g., epilepsy)

Mental Health Concerns (e.g., Depression, Anxiety Disorder, Bipolar)

Childhood deaths Birth defects Dysmorphology Substance abuse

Please add any comments such as frequent miscarriages or suspected but unconfirmed autism in relative:

**SOCIAL HISTORY:**

Please indicate who the child resides with.

Biological parents Foster home placement Grandparent

Mother Father

Mother and Partner Father and Partner

Splits time between households Other

List other significant caregivers that live outside the home (e.g., family, friends, grandparents, neighbor)

Other:

Has legal custody of the child: Both parents Mother Father Grandparent

Children Protective Services Other



Other:

Biological parents are: Married

Never married Separated Divorced Widowed



How many people live in the home not including the 1

child? 2



3

4

5

6

Is English the primary language at home?  Yes  No

List the primary language used at home:

Any concern for trauma or abuse (physical, sexual, mental, observed domestic violence) present or in the past?  Yes  No

Please describe the concern for trauma:

**SCHOOL SERVICES:**

Current school enrollment, choose all that apply:

Please indicate if they are or were previously enrolled in (attended) developmental preschool or birth to three. (you may choose more than one response)

Attending/attended Birth to Three

Attending/attended Developmental Preschool (through the school district) Enrolled in public school

Enrolled in private school or preschool Enrolled in home school program

Enrolled in a transition program (graduated from high school) Enrolled in college

Not enrolled in school other

Please describe their school situation:

Grade level: Preschool

Kindergarten 1st



2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

high school graduate Not enrolled in school

(if summer vacation, which grade will they be in the Fall)

Ever repeat a grade?  Yes  No

Education Program:

Which best describes their current education program?

full time general or regular education classroom splits time between regular and special education classes (resource room)

self contained education classroom has IEP

has section 504 receives speech

receives occupational therapy receives physical therapy receives social skills support receives academic support

Has aid or para-educator support other

Please describe their educational program

Are there any reported concerns at school about behaviors, social interactions or academic problems?  Yes  No

Please describe behavior or social concerns: (do they have friends at school, do they struggle during

unstructured times such as recess and/or lunch)

Are there learning problems? (Please check all that apply) Math Reading Writing

Explain:

Has any academic testing been done?  Yes  No  Unknown

Results:

Has any cognitive or Intelligence testing been done?  Yes  No  Unknown

Results:

Enrollment in therapies/activities outside of school?

None

Speech therapy Occupational therapy Physical therapy Social Skills group Mental Health Therapy

Enrolled in sports program (swim, soccer, etc) Engaged in community social group (scouts/ 4H, youth church group, etc)

Enrolled in music program' other

Please describe the therapies they are enrolled in outside of school:

**REVIEW OF SYSTEMS**

General Growth/Health concern Yes



-including recent weight change or decreased growth No

Please briefly describe the health or growth concerns.

Hearing concerns: Yes

- including lack of up to date hearing test No



Please describe hearing concerns:

Vision concerns: Yes

No



Please describe the vision concern:

Neurologic concerns: Yes

-including history of seizures, concussion, or tics. No



Please describe the neurologic concerns:

Gastrointestinal concerns: Yes

-including constipation or diarrhea. No



Please describe GI concerns:

Diet concerns: Yes

-including being a picky eater. No



Please check all of the following that apply:

Problem eater (Less than 10 foods) Picky eater (Less than 20 foods) Special Diet

Pica (Eating/craving non-food items) Chewing or swallowing issues

History of growth concerns - Overweight History of growth concerns - Underweight other

Please describe your concerns about the child's diet:

Which beverages does the child drink regularly?

Water Milk Juice/Sweetened beverages

Approximately how much water does the child drink per day?

((oz))

How often is water accessible?

 At meals/snack times  Access to water available all day

Approximately how much milk does the child drink per day?

((oz))

Does child drink more than 24 oz milk per day?  Yes  No

How often is milk accessible?

 At meals/snack time  Access to fluids available all day

Approximately how much juice does the child drink per day?

((oz))



Does child drink more than 24 oz juice per day? Yes No

How often is juice accessible? At meals/snack time

Access to juice available all day



Sleep concerns: Yes

-including difficulty falling asleep, staying asleep No (takes more than 30 minutes), waking up early, waking



up during the night, restlessness or snoring.

Please describe the sleep concerns:

Skin concerns: Yes

-including skin findings such as unusual birth marks No or severe eczema



Please describe concerns about your patient's skin.

Musculoskeletal concerns: Yes

-including muscle weakness or joint pain. No



Please describe your patient's muscular skeletal concerns:

Cardiac/Respiratory concerns: Yes



-including history of murmurs or breathing No difficulties.

Please describe the cardio or respiratory concerns:

Allergic/Immunologic concerns: Yes

-including environmental allergies or frequent No illnesses.



Please describe concern regarding allergies or immune function:

Hygiene concerns: Yes

-including toileting, dressing or grooming. No



Please describe the concern regarding hygiene:

Behavior Concerns

Anxious or worries Short attention span Hyperactivity Obsessive-compulsive Aggressive

Hurting animals or other people Unusual or excessive fears Depression

Defiant

Self-injury (e.g., head banging, biting, scratching, cutting, picking, etc.) Toileting issues, accidents

Irritability/Moodiness Hallucinations

None of the above other

Severity Level of Behavior Concerns  Minimal  Moderate  Severe

Examples of developmental or behavioral concerns:

Physical Exam concerns:

-including dysmorphic features, macrocephaly, atypical neurologic findings, etc  Yes  No

Please describe physical exam findings:

Would you want ECHO guidance regarding concerns raised in the review of systems? For example, dietary or behavioral support?

 Yes  No

Please describe:

**Developmental History**

Has there been significant loss of an acquired skill or skills?  Yes  No

Explain significant loss:

Age started walking independently.

Concern about gross or fine motor skills:  Yes  No

Describe concern about gross or fine motor skills:

Early Social Skills: As an infant, when the caregiver attempted to engage the child, how did the child respond?

did not respond to own name did respond to own name

did not enjoy social games such as peek-a-boo did enjoy games such as peek a boo

caregiver does not remember or do not know other

Please describe the response to parents when they were an infant:

Early language skills were one time, saying first words around age 1 and combining words around age 2?  Yes  No

Please describe the early language development:

Communication Ability (Please indicate the child's highest communication)

Nonverbal (i.e., no functional words) Uses single words

Uses 2-3 word phrases Uses sentences

Chats with others (e.g., reciprocal conversation)

Uses gestures (e.g., pointing, waving and/or leads other to wants/needs)

Do you have a question if this patient meets criteria for autism?  Yes  No

Please describe your current plan of care for this patient:

When you are done with this plan, you are done with the presentation form and do not need to complete the DSM 5 questions.

**DSM 5 QUESTIONS: Below are the diagnostic criteria for autism regarding deficits in social communication. We know you probably have not asked all these questions, but this matrix will**

**help identify your confidence in the presence of the diagnostic criteria.**

SOCIAL COMMUNICATION

**Social Emotional Reciprocity**

**Indicate which if the following deficits were reported or observed.**

* Difficult to Engage
* Poor Quality of Social Initiation
* Poor Quality of Social Response
* Own terms/Own Agenda
* Difficulty Sustaining Interactions
* Limited initiation of joint attention
* Reduced showing or sharing of interests
* Reduced interest in others' interests or excitement
* Difficulty with Imitation
* Lack of responsive social smile
* Failure to offer comfort to others

Not deficit Probably

not deficit

Maybe

deficit

Probably

deficit

Definitely

deficit

Not

assessed or unsure

Observed

* Indifference/aversion to physical contact and affection
* Makes Socially Inappropriate Comments
* Engages in socially inappropriate behavior
* Does not pick up on or appropriately respond to others' social cues
* Poor Topic Maintenance, if conversational
* Interrupting/Turn-Taking, if conversational
* Talks incessantly, if conversational
* Own Interests, if conversational
* Does not ask Questions for Social Purposes, if conversational
* Inconsistent response to

others' bids for conversation

Please describe deficits in social emotional reciprocity:

**Nonverbal Communicative Behaviors Used for Social Interaction**

**Indicate which if the following deficits were reported or observed.**

* Avoids eye contact
* Inconsistent eye contact
* Poor coordination of eye gaze with other means of communication

Not deficit Probably

not deficit

Maybe

deficit

Probably

deficit

Definitely

deficit

Not

assessed or unsure

Observed

* Uses others' bodies as a tool for communication
* Does not use Conventional gestures (pointing, waving, nodding, etc.)
* Decreased use of gestures (Descriptive or Emphatic gestures )
* Exaggerated use of gestures
* Impairment in use of Body Posture during interactions (not facing partner)
* Does not direct facial expressions to others
* Decreased use of facial expressions
* Directs only emotional extremes
* Does not interpret facial expressions/nonverbal cues of others
* Exaggerated facial expression
* Unusual prosody, intonation, use of inflection
* Uses verbal and nonverbal communication, but not well coordinated

Please describe Nonverbal Communicative Behaviors Used for Social Interaction

**Developing and Maintaining Relationships**

* Poor Peer Interactions
* Lack of Social Motivation
* Social Interest but lacks Social Skills
* Difficulty in engaging in imaginative play with peers
* Lack of cooperative play (over 24 months developmental age); parallel play only

Not deficit Probably

not deficit

Maybe

deficit

Probably

deficit

Definitely

deficit

Not

assessed or unsure

Observed

* Difficulty making friends
* Does not try to establish friendships
* Does not have preferred friends
* Does not play in groups of children
* Does not play with children his/her age or developmental level (only older/younger)
* Does not respond to the social approaches of other children
* Difficulty adjusting behavior to suit different contexts
* Misinterprets others' actions
* Does not recognize when being teased
* Limited understanding of friendships

Describe deficits in developing and maintaining relationships:

Restricted Interests/Repetitive Behavior

**Stereotyped or repetitive speech, motor movements, or use of objects**

* Repetitive Motor Mannerisms
* Repetitive Action on Objects
* Presence of Echolalia (immediate or delayed)
* Use of Scripted Communication (Overly formal, Overused phrases, Quoting from movies or previous experiences, Use of neologisms)

Not deficit Probably

not deficit

Maybe

deficit

Probably

deficit

Definitely

deficit

Not

assessed or unsure

Observed

**Excessive adherence to routines, ritualized patterns of behavior, or excessive resistance to**

**change**

* Difficulty with Transitions
* Categorization or organization of materials
* Rigidity

Not deficit Probably

not deficit

Maybe

deficit

Probably

deficit

Definitely

deficit

Not

assessed or unsure

Observed

* Insistence on specific nonfunctional routines or rituals
* Upset if Routines are disrupted
* Insistence on others' performing some routine (verbal or nonverbal)

Describe details regarding excessive adherence to routines, ritualized patterns of behavior, or excessive resistance to change:

**Highly restricted, repetitive, overly focused interests**

* Presence of Restricted Interests
* Preoccupation with unusual objects
* Excessively circumscribed interest

Not deficit Probably

not deficit

Maybe

deficit

Probably

deficit

Definitely

deficit

Not

assessed or unsure

Observed

Please describe the highly restricted, repetitive, overly focused interests:

**Sensory sensitivities, aversions, and/or sensory seeking behavior**

* Auditory (Hyper- or Hypo-): sensitive to motor sounds
* Visual (Hyper- or Hypo-): peers at objects out of corner of eye

Not deficit Probably

not deficit

Maybe

deficit

Probably

deficit

Definitely

deficit

Not

assessed or unsure

Observed

* Tactile (Hyper- or Hypo-): sensitive to clothing, high pain tolerance
* Vestibular (Hyper- or Hypo-): likes to spin
* Smell (Hyper- or Hypo-): smells non-food items

Describe presence of sensory sensitivities, aversions, and/or sensory seeking behavior:

**Contra-Indicators for autism:**

Describe any contra-indicators for autism:

This would be social strengths that do not support a diagnosis of autism

**Confidence in autism diagnosis**

How confident do you feel about the diagnosis of autism for this patient?

1=Definitely not autism 2=Probably not autism 3=Maybe autism 4=Probably autism 5=Definitely autism

**Plan of Care**

Please describe your current plan of care for this patient: