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 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 child?

- ◯ 1
- ◯ 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
-including recent weight change or decreased growth
◯ Yes
◯ No

Please briefly describe the health or growth concerns.

_____

Hearing concerns:
- including lack of up to date hearing test
◯ Yes
◯ No

Please describe hearing concerns:

_____

Vision concerns:
◯ Yes
◯ No

Please describe the vision concern:

_____

Neurologic concerns:
-including history of seizures, concussion, or tics.
◯ Yes
◯ No

Please describe the neurologic concerns:

_____

Gastrointestinal concerns:
-including constipation or diarrhea.
◯ Yes
◯ No

Please describe GI concerns:

_____

Diet concerns:
-including being a picky eater.
◯ Yes
◯ 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:
-including difficulty falling asleep, staying asleep (takes more than 30 minutes), waking up early, waking up during the night, restlessness or snoring.

◯ Yes
◯ No

Please describe the sleep concerns:

_____

Skin concerns:
-including skin findings such as unusual birth marks or severe eczema

◯ Yes
◯ No

Please describe concerns about your patient's skin.

_____

Musculoskeletal concerns:
-including muscle weakness or joint pain.

◯ Yes
◯ No

Please describe your patient's muscular skeletal concerns:

_____

Cardiac/Respiratory concerns:
-including history of murmurs or breathing difficulties.

◯ Yes
◯ No

Please describe the cardio or respiratory concerns:

Allergic/Immunologic concerns:
-including environmental allergies or frequent illnesses.

◯ Yes
◯ No

Please describe concern regarding allergies or immune function:

Hygiene concerns:
-including toileting, dressing or grooming.

◯ Yes
◯ 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.

	Not deficit	Probably not deficit	Maybe deficit	Probably deficit	Definitely deficit	Not assessed or unsure	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	☐	☐	☐	☐	☐	☐	☐

□ 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.

	Not deficit	Probably not deficit	Maybe deficit	Probably deficit	Definitely deficit	Not assessed or unsure	Observed
□ Avoids eye contact	☐	☐	☐	☐	☐	☐	☐
□ Inconsistent eye contact	☐	☐	☐	☐	☐	☐	☐
□ Poor coordination of eye gaze with other means of communication	☐	☐	☐	☐	☐	☐	☐
□ 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

	Not deficit	Probably not deficit	Maybe deficit	Probably deficit	Definitely deficit	Not assessed or unsure	Observed
□ 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	☐	☐	☐	☐	☐	☐	☐
□ 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

	Not deficit	Probably not deficit	Maybe deficit	Probably deficit	Definitely deficit	Not assessed or unsure	Observed
□ 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)	☐	☐	☐	☐	☐	☐	☐

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

	Not deficit	Probably not deficit	Maybe deficit	Probably deficit	Definitely deficit	Not assessed or unsure	Observed
□ 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

	Not deficit	Probably not deficit	Maybe deficit	Probably deficit	Definitely deficit	Not assessed or unsure	Observed
□ Presence of Restricted Interests	☐	☐	☐	☐	☐	☐	☐
□ Preoccupation with unusual objects	☐	☐	☐	☐	☐	☐	☐
□ Excessively circumscribed interest	☐	☐	☐	☐	☐	☐	☐

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

Sensory sensitivities, aversions, and/or sensory seeking behavior

	Not deficit	Probably not deficit	Maybe deficit	Probably deficit	Definitely deficit	Not assessed or unsure	Observed
□ Auditory (Hyper- or Hypo-): sensitive to motor sounds	☐	☐	☐	☐	☐	☐	☐
□ Visual (Hyper- or Hypo-): peers at objects out of corner of eye	☐	☐	☐	☐	☐	☐	☐
□ 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: