



Hospital for Special Care Autism Inpatient Unit
Parent or Guardian Questionnaire

Date: _____

Patient's Demographic Information

Form with fields for Patient's Name, Date of Birth, Age, Address, Preferred Name, Preferred Pronouns, Gender assigned at birth, Gender Identity, Sexual Orientation, Race, Ethnicity, Patient Primary Language, Parent Primary Language, Height, Weight, Patient is (Verbal/Nonverbal), and Social Security Number.

Parent/Guardian Information

Form with fields for Name, Relationship to Child, Mailing Address (Street, City/State, Zip), Primary Contact (Phone, Cell, Email), and Secondary Contact (Phone, Cell, Email).

Insurance Information:

Please attach a copy of the insurance card

Form with fields for Primary Insurance (Subscriber Name, Phone, ID#, Relationship, DOB) and Secondary Insurance (Subscriber Name, Phone, ID#, Relationship, DOB).



Autism Diagnostic Evaluation (Note: Must attach written report of evaluation by a Psychologist or MD, outside of school, who used one of the following tests to diagnose Autism: CARS, GARS, or ADOS)

Please list your child's care providers along with their contact information:

Psychiatrist:	Phone Number:
	Email:
Primary Care Physician:	Phone Number:
	Email:
Therapist	Phone Number:
	Email:
ABA Provider	Phone Number:
	Email:
DCF/DDS Worker	Phone Number:
	Email:
Medical Subspecialist	Phone Number:
	Email:

**Is your child currently taking any prescription or over-the-counter medications (including vitamins and supplements)?
Please list them here:**

Medication	Treating what Problem	Prescribing MD



Current Diet and Food Allergies: No Known Food Allergies Ingests non-food items? (PICA) Y N

Please list any allergies your child has to medications or the environment/sensory sensitivities:

Please describe the problem behaviors that your child exhibits, from most to least concerning:

Problem Behavior	Frequency (e.g., hourly, weekly)	Problems Caused (e.g., injuries, property damage)



Please describe your child's sleep pattern:

Self-Care/Activities of Daily Living:

- Toilet Trained
 Wears diapers
 Fecal Smearing
 Other: _____
 Does your child need support with:
 Bathing/showering
 Brushing Teeth
 Feeding
 Dressing

How does your child communicate with you?

How old was your child when he/she was first diagnosed with ASD? Who made the diagnosis?

What is your child's level of intellectual disability (ID)?

- Normal/None
 Mild ID
 Moderate ID
 Severe ID
 Profound ID
 Unspecified ID

What psychiatric diagnoses, if any, does your child have? (i.e., Anxiety disorder)

Please list previous ED visits for behavioral reasons (please include date & facility):

Please list previous hospitalizations for behavioral reasons (please include date & facility):



Does your child have any medical diagnoses? (e.g., GERD, Diabetes Insipidus, seizures (date of last seizure))

Are there any medical procedures or equipment your child needs on a regular basis? (i.e., CPAP, wound care, AFOs)

What methods/techniques work best to help calm/soothe your child?

What are your child's strengths/interests?

What are the things that typically upset your child/cause them to act out behaviorally?

Current Services (Respite, in-home ABA, etc.):

Anticipated goals of program:



Hospital for Special Care

We rebuild lives.

Submit all documents to:
Autism Admissions Coordinator:
Kayla Santiago
Ksantiago@hfsc.org
P: 860-827-4841
F: 860-832-6273

Education:

Is your child currently in school? [] Yes [] No If yes, School Name: _____

School District: _____

What type of classroom?

- [] Mainstream Classroom [] Special Ed Classroom [] Special Ed School [] Not attending school
[] Other: (Describe) _____

Name of teacher:

Email: _____ Phone: _____

Does your child receive services outside of school? [] Yes [] No

If yes, name of program & services received: _____

Has your children been seen at the HFSC Autism Center? [] Yes [] No If yes, date of last visit: _____

Discharge Planning:

I understand my child will return to current living situation, Hospital for Special Care does not participate in recommendations or placements at any residential settings. _____ (initial)

Resources: If available please include any/all of the following:

- [] Insurance card(s) front & back [] Pertinent Office Notes/Lab Results
[] Clinician Referral Form [] Educational Testing and latest IEP
[] ASD Testing [] Current Medication list
[] Behavior Plans/Assessments [] Incident Reports
[] Copy of Legal Guardian or Conservator document if patient is 18+ years of age
[] Any materials you think would be beneficial in helping understand/plan for your child

Signature of Legal Guardian:

Signature _____ Print Name _____ Date _____

Please note that all referrals will be reviewed in a timely fashion and decisions for placement are dependent on both your child's needs and the current milieu of the program. Referrals are deemed active for 30 days and then, if hospitalization is still needed, updated clinical information will be requested. We encourage you to alert the team of any major changes in behavior, hospitalization/ED visits or anything else that you feel is important to know when reviewing your referral.