hfsc Hospital for Special Care

Hospital for Special Care Autism Inpatient Unit
Parent Questionnaire

DWWDFKPHQW

Anticipated goals of program:

Education:

Is child currently in school? (circle one) Y N If yes, school name: _____

School district: _____

What type of classroom? (circle one)

Main stream classroom Special Ed Classroom Special Ed School Other: (describe) _____ N/A

Name of teacher: _____ School phone number:_____

Does your child receive services outside of school? Y N

If yes, name of program & services received:_____

_____

_____

Has your child been seen at the HFSC Autism Center? Y N

If yes, date of last visit: _____

Discharge Planning: Where will your child will be discharged to (home, group home other)?

Signature of Legal Guardian:

_____ _____ _____

Signature Print Name Date

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

- ASD Testing
- Pertinent Office Notes/Lab Results
- Educational Testing and latest IEP & PPT
- Behavior Plans/Assessments
- Incident Reports
- Any materials you think would be beneficial in helping understand./plan for your child