Hospital for Special Care

Hospital for Special Care Autism Inpatient Unit
Parent Questionnaire

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Date: _____

Patient's Demographic Information:

Patient Name: _____ DOB: _____ Age: _____

Address: _____

Gender: __M __F Height: _____ Weight: _____ Patient is: __Verbal __Nonverbal

Ethnicity: ____ Hispanic ____ Non-Hispanic

Race: ____American Indian ____Asian/Pacific Island ____Black ____ White ___Other ___Prefer not to answer

Social Security Number: _____

Parent/Guardian Information:

Name: _____ Relationship to the child: _____

Mailing Address: _____

(Street) (City/State) (Zip)

Primary Contact: _____ Relationship: _____

Phone # (H): _____(Cell): _____ Email:_____

Parent/Guardian primary language: _____ Interpreter Needed? _____

Insurance Information:

Primary Insurance: _____ ID #: _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ ID#: _____

Subscriber Name:_____ Relationship: _____DOB:_____

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

Psychiatrist	Phone #
Medical	Phone #
Therapist	Phone #
Medical	Phone #
DCF Worker	Phone #
Medical Subspecialist	Phone #

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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)

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

Medication	Treating what problem?	Prescribing MD

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

Current diet and Food Allergies ☐ **No Known Food Allergies**

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)? (circle one)
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)

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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)

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

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.):

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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

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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.