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

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Hospital for Special Care Autism Inpatient Unit
Parent or Guardian Questionnaire

Date: _____

Patient Demographic Information

Patient's Name:		Date of Birth:	Age:
Address/City/State/Zip:			
Preferred Name:	Preferred Pronouns:	Gender Assigned at Birth: ☐Male ☐Female	
Gender Identity: ☐Male ☐Female ☐Non-Binary ☐Transgender ☐Other: _____ ☐Choose not to disclose		Sexual Orientation: ☐Straight/Heterosexual ☐Lesbian/Gay/Homosexual ☐Bisexual ☐Don't know ☐Other:_____ ☐ Choose not to disclose	
Race: ☐ Black/African American ☐White ☐Asian ☐Asian Indian ☐ Other Pacific Islander ☐American Indian ☐Other:_____ ☐ Choose not to disclose			
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Puerto Rican ☐ Cuban ☐ Mexican/Mexican American ☐ Other:_____ ☐ Choose not to disclose			
Patient Primary Language: Interpreter needed: ☐ Yes ☐No		Parent Primary Language: Interpreter needed: ☐ Yes ☐No	
Height:	Weight:	Patient is: ☐Verbal ☐ Nonverbal Nonverbal AAC device? ☐ Yes ☐ No	

Parent/Guardian Information

Name:		Relationship to Child:	
Mailing Address: Street		City/State	Zip
Primary Contact:		Relationship to Child:	
Phone:	Cell:	Email:	
Secondary Contact:		Relationship to Child:	
Mailing Address: Street		City/State	Zip
Phone:	Cell:	Relationship to Child:	

Insurance Information: ***Please attach a copy of the insurance card***

Primary Insurance:	ID#:
Subscriber Name:	Relationship:
Subscriber Phone:	Subscriber DOB:
Secondary Insurance:	ID#:
Subscriber Name:	Relationship:
Subscriber Phone:	Subscriber DOB:

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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

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

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)

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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)?
☐ Norman/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 and facility):

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

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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/sooth 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:

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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 and services received:_____

Has your child been seen at the HFSC Autism Center ☐Yes ☐No
If yes, date of last visit:_____

Discharge Planning:

I understand my child will return to the 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
☐ Clinician Referral Form
☐ ASD Testing
☐ Behavior Plans/Assessments
☐ Pertinent Office Notes/Lab Results
☐ Educational Testing and latest IEP
☐ Current Medication List
☐ 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.