

**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: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose | | Sexual Orientation: <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Lesbian/Gay/Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't know <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose | |
| Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose | | | |
| Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican/Mexican American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose | | | |
| Patient Primary Language: Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Parent Primary Language: Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Height: | Weight: | Patient is: <input type="checkbox"/> Verbal <input type="checkbox"/> Nonverbal Nonverbal AAC device? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | |

Parent/Guardian Information

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

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: |



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

[Empty text box for diet and food allergies]

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

[Empty text box for allergies]

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

Table with 3 columns: Problem Behavior, Frequency (e.g., hourly weekly), Problems Caused (e.g., injuries, property damage). Contains 4 empty rows for data entry.



Describe your child's sleep pattern:

[Empty text box for sleep pattern description]

Self-Care/Activities of Daily Living:

- checkboxes for Toilet Trained, Wears diapers, Fecal Smearing, Other: _____

Does your child need support with:

- checkboxes for Bathing/showering, Brushing Teeth, Feeding, Dressing

How does your child communicate with you?

[Empty text box for communication description]

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

[Empty text box for diagnosis details]

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

- checkboxes for 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)

[Empty text box for psychiatric diagnoses]

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

[Empty text box for ED visits]

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

[Empty text box for hospitalizations]



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:



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 [] 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.