UNM CENTER FOR Development and Disability
UNM Medical Group, Inc.

2300 Menaul Blvd. NE
Albuquerque, NM 87107
505.272.3000 fax:505.272.2014
http://www.cdd.unm.edu

Autism Spectrum Evaluation Clinic: Instructions and Checklist

Please keep this checklist for your records

Thank you for contacting the Center for Development and Disability Autism Spectrum Evaluation Clinic. Our program provides comprehensive, team evaluations for Autism Spectrum Disorder and other developmental disabilities for children three years and older.

Please provide the following information to prepare the team for your child's evaluation. CDD-UNMMG consent forms must be signed by the client's legal guardian.

- ***CDD Child Information Form*** (3 pages)
- ***Autism Spectrum Evaluation Clinic-Child Information Addendum*** (4 pages)
- ***CDD Consent to Treat*** form signed by legal guardian
- ***Patient Registration*** form including insurance information
- ***Race and Ethnicity*** form signed by legal guardian
- ***Teacher Questionnaire***
- Copies of any previous developmental or medical reports
- Copies of school records, including any special education evaluations or current Individualized Educational Program (IEP) reports.

  If you would like our staff to request records, please complete **one** ***Authorization to Request Health Information*** form for each school or agency.

Your child will be added to our waiting list when the packet is received. We will send you a confirmation letter, with an estimate of when you may expect to be scheduled. Please note, that currently our waiting list is **twelve to sixteen months.**

Fax or mail completed packet to:

Center for Development and Disability
Clinical Services - Autism
2300 Menaul Blvd, NE.
Albuquerque, NM 87107
Fax# 505.272.2014

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Child Information

Please complete all sections

INTAKE INFORMATION

Who is completing this form? _____ Today's date: _____
Name and relationship to child

Who is referring? _____ Referrer's phone: _____
Name and relationship to child

CHILD'S INFORMATION

Name:_____ Date of birth: _____

Sex: M F

Primary language: _____ Other languages: _____

PEDIATRICIAN / PRIMARY CARE PROVIDER

Name: _____

Phone: _____ Fax: _____

Address: _____

PARENTS/CAREGIVERS

Are the Parents the legal guardians for this child? □ *Yes* □ *No*

1. Name: _____ 2. Name: _____

Relationship: _____ Relationship: _____

Email address: _____ Email address: _____

Mailing address: _____ Mailing address: _____

_____ _____

Phones: _____/_____ Phones: _____/_____
Primary *Other* *Primary* *Other*

Legal Guardians, Foster Parents or Other Caregivers:

1. Name: _____ 2. Name: _____

Relationship: _____ Relationship: _____

Email address: _____ Email address: _____

Mailing address: _____ Mailing address: _____

_____ _____

Phones: _____/_____ Phones: _____/_____
Primary *Other* *Primary* *Other*

Is the Children, Youth and Families Department (CYFD), or other protective service agency, involved with the child or family? □ *Yes* □ *No*

If yes, please provide the CYFD Social Worker or contact:

Name: _____ Phone: _____ Email: _____ Fax: _____

Child's Name: _____ *MRN:*_____

Who lives in the home with the child?

Name	Age	Relationship to Child	Primary Language
1.			
2.			
3.			
4.			
5.			
6.			

If English is not the native language for yourself or your child, will an interpreter be needed for the evaluation?

□ *Yes* □ *No* *If yes, what language?* _____

SERVICE PROVIDER INFORMATION

Is the child currently in intervention services? *(For example: early intervention, school, other therapy services, etc.)*

□ *Yes* □ *No*

Please provide the following information regarding current intervention services:

Therapist	Name	Agency/School	Phone
Developmental Specialist			
Speech Language Pathologist			
Occupational Therapist			
Physical Therapist			
Social Worker/Counselor			
Hearing Specialist			
Special Education			
Vision Specialist			
Other:			
Other:			

CONCERNS / QUESTIONS

Check all boxes below that best describe the nature of your concern(s):

□ Accidents / Injuries
□ Allergies
□ Asthma
□ Attention
□ Autism Spectrum Disorder
□ Behavioral Difficulties
□ Coordination / Balance
□ Ear Infections
□ Epilepsy / Seizures
□ Family Stressors
□ Feeding / Nutrition
□ Hearing
□ Learning / Thinking
□ Medical / Health
□ Motor (Use of arms/legs)
□ Premature / Complex Birth
□ Prenatal Exposures
□ Sensory / Regulation
□ Sleep
□ Special Equipment
□ Speech / Language
□ Vision
□ Other: _____
□ Other: _____

Child's Name: _____ *MRN:*_____

Please explain your concerns or questions: _____

_____

_____

What do you hope to gain from this evaluation? _____

_____

_____

What does the child do well? _____

_____

What activities does the child enjoy? _____

_____

_____

MEDICAL/DEVELOPMENTAL INFORMATION

When was child's most recent hearing screening/test? _____ *Results?* Pass Fail

When was child's most recent vision screening/test? _____ *Results?* Pass Fail

Does the child have medical, behavioral, and/or developmental diagnoses? *(For example: Fragile X, ADHD, seizure disorder, Autism Spectrum Disorder, etc.):* □ *Yes* □ *No*
If yes, please list: _____

_____

Does the child take medication? □ *Yes* □ *No*
If yes, please list: _____

_____

When did the child first do the following:

	Age	**Not Yet**	**Not Sure**
Rolled over			
Sat without help			
Crawled on hands and knees			
Walked without help			
Said single words			
Put two or more words together (e.g., “green car”)			
Talked in short sentences (e.g., “Daddy has a green car”)			
Toilet trained (during the day)			
Toilet trained (overnight)			

Did the child ever lose any of the above skills? □ *Yes* □ *No*
If yes, please describe: _____

_____

Please feel free to attach any additional information that you would like to provide.

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Autism Spectrum Evaluation Clinic

Child Information Addendum

Please complete all sections - 4 pages

Child's Name:_____

FAMILY MEDICAL HISTORY

Is there any history of developmental or behavioral issues in the child's immediate family?
Please check all that apply.

	Mother	Father	Sibling	Grandparent	Other (Aunts, Uncles, Cousins)
Autism Spectrum Disorder					
Language Problems					
Learning Problems					
Attention Problems					
Other Developmental Delays					
Genetic Conditions					
Neurological Problems					
Seizures					
Anxiety					
Depression					
Alcohol or Substance Abuse					
Other mental health or behavior issues					

CHILD MEDICAL HISTORY

Were there any problems or complications during **pregnancy?** □ *Yes* □ *No*
If yes, please explain:

_____

_____

_____

If the child's mother used any of the following during the pregnancy, please check and describe.

☐ Vitamins or Supplements
☐ Prescription Medications
☐ Tobacco
☐ Alcohol
☐ Other drugs

Were there any problems or complications during **delivery?** □ *Yes* □ *No*
If yes, please explain:

_____

_____

_____

Was the child born on time? □ *Yes* □ *No* Weeks Early _____ Weeks Late _____

Type of Delivery: _____ Birth Weight:_____

Were there any problems, complications or hospitalizations after birth? □ *Yes* □ *No*
If yes, please explain:

_____

_____

_____

Please describe the child's temperment/personality during the first few months:

_____

_____

_____

Has the child been affected by any of the following? Check any that apply

If yes, please note age and explain each checked area.

	Age	Comments
☐ Hospitalization		
☐ Concern for Seizures		
☐ Allergies		
☐ Significant Illness		
☐ Injuries		
☐ Medical studies or specialist consults		
☐ Sleep concerns		
☐ Feeding/diet concerns		
☐ Other concerns (please specify)		
☐ Other concerns (please specify)		

Please list all medical diagnoses your child has been given, with age, date, and provider who made the diagnosis.

Diagnosis	**Age**	**Date**	**Provider/Agency**

Please list any medications the child takes currently:

_____

_____

_____

_____

_____

Has the child been affected by any of the following?
Please check any that apply, and explain each checked area.

☐ Adoption
☐ Foster care
☐ Domestic violence
☐ Physical or sexual abuse
☐ Divorce/remarriage
☐ Drug or alcohol use
☐ Serious family illness
☐ Household moves
☐Other concerns(please specify)

EDUCATIONAL SERVICES

Has the child ever received special education services in school?

□ Never requested/referred □ Denied eligibility □ Waiting for evaluation

□ Has current IEP □ Had IEP in the past, not now

When was the child last tested for special education services?

Date:_____ Age:_____ Grade:_____

Please include copies of previous evaluations or treatment records, if available:

- Reports for any school evaluations
- Current Individualized Educational Program report
- Behavioral health assessments (e.g., psychology, social work)
- Reports from medical specialists (e.g., genetics, neurology)

If you would like our staff to request records directly from other providers, schools or agencies, please complete and sign "Authorization to Release Health Information" forms.

Please feel free to attach any additional information that you would like to provide.

UNM Medical Group, Inc.
University of New Mexico Physicians

Center for Development and Disability

Consent to Treatment and Assignment of Benefits

1. I, the undersigned, hereby request and consent to medical treatment by the Center for Development and Disability or UNM Medical Group, Inc. and its physicians and staff (including administration of medication, tests and procedures) as deemed necessary.
2. I hereby assign and request payment directly to the Center for Development and Disability and UNM Medical Group, Inc. of any insurance or other authorized health benefits otherwise payable to me for medical treatment rendered, and to release any information required to the insurance company for consideration of payment for services.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship to Patient

Revised: 8/2014

UNM CENTER FOR Development and Disability
UNM Medical Group, Inc.

Patient Demographic Form

UNM MEDICAL GROUP, INC.
Center for Development and Disability
2300 Menaul Blvd NE
Albuquerque, New Mexico, 87107
Phone: (505) 272-3000 **Fax:** (505) 272-5280

PATIENT INFORMATION

Patient's Name (Last, First, MI):_____DOB:_____

Address:_____ Phone:_____

City:_____ State: _____ Zip: _____ Tribe:_____

Patient's SSN:_____ Sex: M F Race/Ethnicity:_____

Patient's Marital Status:_____ If Married, Name of Spouse:_____

Patient's Employment Status:_____ Occupation:_____

Employer Name:_____ Employer Phone: _____

Employer Address:_____ Email Address: _____

PARENT / GUARDIAN (IF PATIENT IS A MINOR)

Name:_____ Relationship:_____

Address:_____

City:_____ State: _____ Zip: _____ Phone: _____

NEXT OF KIN / EMERGENCY CONTACT INFORMATION

Next of Kin:_____ Relationship:_____

Address:_____

City:_____ State: _____ Zip: _____ Phone: _____

REFERRING PHYSICIAN

Physician Name:_____ Phone/Fax:_____

Address:_____

INSURANCE INFORMATION

Is patient covered under Medicare/Medicaid? (please circle)Yes / No Medicare/Medicaid #:_____
If covered under Medicaid, which salud? (please circle) Molina / BCBS / Lovelace / Presbyterian
Is patient covered under Insurance? (please circle) Yes / No If yes, please provide the following:

Policy holder's Name: _____ Policy holder's DOB:_____

Policy holder's SSN:_____ Relationship to Patient:_____

Insurance Company:_____ Phone:_____

Address:_____

Group #:_____ Policy #:_____ Authorization #:_____

Policy holder's Employer:_____ Occupation:_____

Employer Address:_____

City:_____ State:_____ Zip:_____Telephone:_____

UNM CENTER FOR Development and Disability
UNM Medical Group, Inc.

Dear Patient,

UNM Medical Group Inc. wants to give you the best, safest health care possible! Your answers to these questions help us make sure we meet your needs and give the best, safest health care to all patients. Your answers will remain private. Access to this information is very restricted. **Thank you!**

Do you consider yourself Hispanic or Latino?
- ☐ Yes
- ☐ No
- ☐ Don't want to answer

What is your race? **PICK ONE.**
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Anglo
- ☐ Two or more races
- ☐ Don't want to answer

If you do not speak English well, you have the right to a free interpreter. We will provide one for you. In what language do you prefer to **talk** about your health care? **PICK ONE.**
- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Navajo
- ☐ Other: _____

In what language do you prefer to **read** about your health care? **PICK ONE.**
- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ I need help with reading
- ☐ None
- ☐ Other: _____

If you are American Indian/Native American, what tribe(s) or pueblo(s)?
- ☐ Navajo
- ☐ Pueblo: _____
- ☐ Other: _____
- ☐ Other: _____

What is your religion or spirituality?
- ☐ Baptist
- ☐ Buddhist
- ☐ Catholic
- ☐ Christian:_____
- ☐ Jehovah's Witness
- ☐ Jewish
- ☐ Latter-Day Saints/Mormon
- ☐ Muslim
- ☐ Native Traditional
- ☐ Protestant: _____
- ☐ Other: _____
- ☐ None
- ☐ Don't want to answer

What is your relationship status?
- ☐ Single
- ☐ Legally married
- ☐ Domestic partnership/civil union
- ☐ Partnered, living together
- ☐ Partnered, not living together
- ☐ Divorced/permanently separated
- ☐ Widowed/separated by death
- ☐ Other: _____

Patient signature: _____

Date: _____

Thank you! If you have questions, please ask our staff.

(1) Enter data into Cerner,
(2) Place reg sticker here
(3) send form to ILS 2-5399

AUTISM SPECTRUM EVALUATION CLINIC
TEACHER QUESTIONNAIRE

We are evaluating one of your students in the **Autism Spectrum Evaluation Clinic** at the University of New Mexico Center for Development and Disability**.** Your input and comments are invaluable for this process. The family has been requested to have this form completed prior to the child's clinic appointment. If more than one teacher wishes to complete a report, please feel free to xerox and send multiple copies. Please add any additional information that you feel may be helpful.

Child's Name: _____ Date: _____

Teacher: _____ Name of School: _____
Address _____
Grade _____ Type of Class _____
Number of students in class _____ (including regular and special education)
Number of teachers and aides _____

How well do you know this student (please circle your response). How long? _____

Very well Moderately well Not very well

Does this student have an IEP? _____ Category of eligibility?_____

Please list your major concerns about this student:

_____
_____
_____

What are this student's strengths?

_____
_____
_____

How does this student interact with the other students in your class?

_____
_____
_____

Specific questions, concerns and/or areas you would like help with this child:

_____
_____
_____

Thank you for your time. Please return this form directly to parents to send as part of the UNM Autism Spectrum Evaluation Clinic intake packet.

UNM MedicalGroup, Inc.
University of New Mexico Physicians

Center for Development and Disability

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth**:_____ **Medical Record #**:_____

1. I hereby authorize _____ _____
(Name of Disclosing Party) (Phone/Fax of Disclosing Party)
_____
(Address, City, State, Zip of Disclosing Party)

To Disclose to:

☐ UNM Center for Reproductive Health
1701 Moon NE, Suite 200
Albuquerque, NM 87131
505-925-4455

☐ UNM Center for Life
4700 Jefferson Blvd. NE, Suite 100
Albuquerque, NM 87109
505-925-7464

☐ UNM Cardiology Clinic McMahon
4824 McMahon Blvd NW, Suite 109
Albuquerque, NM 87114
505-925-6001

☐ UNM Truman Health Services
801 Encino Place NE, Bldg F
Albuquerque, NM 87102
505-272-1312
Please Fax Request to: 505-272-2240

☐ UNM Center for Development and Disability
2300 Menual Blvd NE
Albuquerque, NM 87107
505-272-3000

☐ UNM Vein and Cosmetic Center
7007 Wyoming Blvd NE, Suite A-3
Albuquerque, NM 87109
505-272-8346

☐ UNM Dental Services @ Camino de Salud Residency Clinic
1801 Camino de Salud, Suite 1200
Albuquerque, NM 87102
505-925-4031

☐ UNM Dental Services @ Novitski Hall
2320 Tucker NE
Albuquerque, NM 87131
505-272-4106

☐ UNM Dental Services @ Camino de Salud Ambulatory Surgical Center
1801 Camino de Salud, Suite 1100
Albuquerque, NM 87102
505-925-7918

☐ UNM Dental Services @ Carrie Tingley
1127 University Blvd, NE
Albuquerque, NM 87106
505-272-5326

2. Information to be disclosed:

☐ most recent visit/admission
☐ history & physical exam
☐ initial assessment
☐ consultation reports
☐ operative report
☐ discharge summary
☐ progress notes
☐ laboratory tests
☐ x-ray reports
☐ pathology reports
☐ ER record/outpatient log
☐ Billing
☐ school records
☐ psychological evaluation
☐ physical therapy evaluation
☐ speech & language evaluation
☐ occupational therapy
☐ Other (please specify)_____

Covering the period(s) of healthcare: from (date)_____ to (date)_____
from (date)_____ to (date)_____

3. I further authorize that this disclosure of health information will include information relating to (initial if applicable): .
   a. acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, or other sexually transmitted diseases ____ initial
   b. behavioral health services/psychiatric care ____initial
   c. treatment for alcohol and/or drug abuse ____ initial
   d. genetic test results and related patient information ____ initial

4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this Authorization and need not sign this Authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed Authorization will be provided to me.

Signature, Patient, or legal representative	(Relationship to patient)	(Date)

Signature of Witness (Date)	(Parent, if CPH/PFC&A patient over 14)	(Date)

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part 2) and State laws (NMSA 1978 §§ 43-1-19, 32A-6A-24, 24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information, and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.