

Temple Memorial
PEDIATRIC CENTER

Temple Memorial Pediatric Center
1710 Moores LN
Texarkana, Texas 75503
(903) 794-2705

Autism Services Screener

Child's name: _____

Date: _____

Has your child been assessed for any disability including Autism? Y/N

If Yes, what type of assessments were given and what were the results?

Assessor's name: _____ Affiliation: _____

Child's age at time of assessment or date of assessment:

Did the assessment include a measure of developmental status/ability? Y/N

Did the assessment include a measure of school readiness/achievement? Y/N

Do you have any medical concern regarding your child? Y/N

If Yes, please describe: _____

What other services does your child currently receive and where/who delivers these services?

Check all that apply:

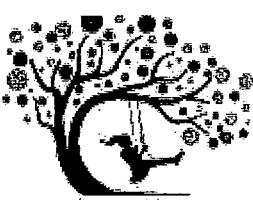
- Occupational therapy: _____
- Physical therapy: _____
- Speech therapy: _____
- Early Childhood intervention: _____
- Preschool program for children with disabilities: _____
- Other preschool/daycare: _____
- Counseling/Psychiatric services: _____

My Child's Communication

- Does not speak
- Speaks in 1-2 word phrases
- Speaks in longer phrases, hard to understand
- Speaks age-appropriately

Describe how your child communicates wants and needs: _____

Describe your communication concerns: _____



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My child's social interactions

- Seems uninterested in others
- Watches others, but limited interactions
- Initiates interactions, but doesn't seem to understand how to interact with others his/her age

Describe how your child interacts with peers and adults: _____

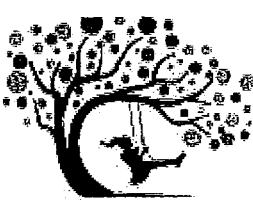
Describe any concerns you have about your child's social interactions: _____

My child's challenging behaviors include

- Aggression
- Property destruction
- Non-Compliance (e.g. saying no, ignoring requests)
- Leaving designated areas
- Tantrum (e.g. screaming, crying, dropping to floor)

Describe your concerns about your child's challenging behavior: _____

My child's dietary or medical restrictions:



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Request for Autism Services

Date _____

Child's Name _____ DOB _____ (age_____) Sex: M F

Parent name(s) _____

Address _____

Phone number _____ (home/cell/work)

Phone number _____ (home/cell/work)

Email address _____

Referring/Primary Care Doctor:

Name: _____ Phone Number _____

Insurance Information:

Company: _____ Phone Number _____

Primary Insured _____ DOB _____

ID# _____ Group _____

OFFICE USE ONLY

TMPC a provider? Y / N ABA covered? Y / N Active Date: _____

Referral needed? Y / N Pre-cert/auth needed? Y / N

Co-Pay \$ _____ Deductible: _____

Out of pocket: _____

Notes: _____

Claims Address: _____

Spoke with: _____ Date _____ Reference# _____