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 theses 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
- ☐ Initates 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 #_____