Boston Children's Hospital
Developmental Medicine Center

Welcome to the Developmental Medicine Center at Boston Children's Hospital

Thank you for your interest in the Developmental Medicine Center (DMC). We provide:

- High quality diagnostic and follow-up care for children with developmental concerns and their families such as:
  - Autism Spectrum Disorders
  - Attention Disorders (ADD/ADHD)
  - Developmental Delays
- Initial appointments may be with one of the following providers or team of providers:
  - Developmental Pediatrician
  - Nurse Practitioner
  - Psychologist
- Resource Specialists: dedicated staff who provide outreach and education

The following steps will need to be completed before we can add your child to the waitlist:

1. **Complete and return all** attached forms to our office by mail, email or fax. **Please do not send your original forms. We encourage you to make copies of all information for your records.**

   Mail: Boston Children's Hospital
   Developmental Medicine Center
   Attn.: Intake Coordinators
   300 Longwood Avenue, Mailstop #3217
   Boston, MA 02115
   Email: DMCIntake@childrens.harvard.edu
   Fax: 617-730-0252

2. Please include copies of any recent documents from early intervention, school or outside providers such as:
   - **IFSP** (Individualized Family Service Plan-report from early intervention services)
   - **IEP** (Individualized Education Program)/**504 Accommodation Plan**
   - School district based **CORE/TEAM evaluations** (educational testing, psychological testing, OT, PT, and/or speech and language evaluations).
   - Any **private or clinic-based testing** (psychological testing, neuropsychological evaluation, OT, PT and/or speech and language evaluations).

3. Once all of this information has been received, **we will call to confirm and provide an estimate of your current wait time** for your initial visit.

The Developmental Medicine Center does not provide evaluations for child abuse and neglect, custody determination, immediate suicidality, IQ testing for gifted placement, or assessment for acute psychiatric conditions. If you need any of the above, please let us know and we can direct you to an appropriate provider.

If you need further information or have any additional questions, please feel free to contact the Center at 617-355-7025.

Thank you,

Lisa Prock, MD, MPH	Kate Linnea, PhD
Director	*Director, Psychology*
Developmental Medicine Center	Developmental Medicine Center

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Insurance Information

Please fill out the below form with accurate information regarding your child's insurance plan(s). This information can be found on the insurance card, or by contacting your insurance company's member service number.

Most insurance companies require prior authorization for neuropsychological or psychological testing and/or mental health visits. Prior authorization is not a guarantee of payment coverage. Many insurers contract with a specific "carve-out" company to administer behavioral/mental health benefits and claims. If your insurer has such a "carve-out," the process for coverage determination and prior approval may be different from those processes used for you medical insurance benefits.

Please call your insurance company to inquire about coverage/benefits under your plan and your required out-of-pocket payments. Coverage policies for individual carriers differ greatly and change frequently.

Parent Name: ______________________________

Primary Insurance Carrier: ______________________________

Group name & number (if applicable): ______________________________

Patient name: ______________________________

Date of birth: ______________________________

Child's identification number: ______________________________

Effective from ______________________ to ______________________ (mm/dd/yyyy)

Subscriber's name & date of birth: ______________________________

Subscriber's address (if different than child's address): ______________________________

____

Important Member service phone number for mental health benefits (usually located on back of insurance card): ______________________________

Secondary Insurance Carrier (if applicable)**:** ______________________________

Group name & number (if applicable): ______________________________

Patient name: ______________________________

Date of birth: ______________________________

Child's identification number: ______________________________

Effective from ______________________ to ______________________ (mm/dd/yyyy)

Subscriber's name & date of birth: ______________________________

Subscriber's address (if different than child's address): ______________________________

____

Important Member service phone number for mental health benefits (usually located on back of insurance card): ______________________________

Your signature below indicates that you have been advised that you may be responsible for paying all charges associated with the visit.

I acknowledge that is any of the above referenced items or services is not considered medically necessary by my insurance company or is a non-covered service, I am financially responsible for the full amount should the claim be denied. If I am denied insurance coverage for any service, discounts may be available.

Guarantor Name: ______________________________ **Guarantor Date of Birth:**_______

Parent/Guarantor Signature: ______________________________ **Date:**__________

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A. GENERAL INFORMATION

Child's Name: *Last ______________________ *First ______________________

*Date of Birth: ______________________ *Gender: ☐M ☐F ☐Other

Current Grade & School Name (if applicable): ______________________

*Person completing questionnaire: ______________________

URGENT CONCERNS

Please **CHECK** any applicable boxes if you have urgent medical concerns.

MEDICAL:

☐ Seizures
☐ Loss of skills/developmental regression
☐ Loss of hearing
☐ Loss of vision
☐ Difficulty swallowing or choking
☐ Severe weakness or lack of coordination
☐ Inability to tolerate exercise
☐ Severe headache
☐ Other (please describe): ______________________

BEHAVIORAL / PSYCHIATRIC

☐ Suicidal thinking or attempt of child
☐ Safety of any family members (including this child)
Please explain: ______________________

**** Please understand that the Developmental Medicine Center has a waiting list. Because some problems need more urgent attention, if your child has any of the above problems, please also contact your pediatrician while you are waiting for your appointment.*

Please list the question(s) you would like answered by this evaluation (*at least one **REQUIRED**)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Who referred your child to the Developmental Medicine Center? (If a provider, please list name and specialty)	
Patient's Primary Care Provider (e.g. pediatrician, nurse practitioner):	
Date of last physical exam:	
Has your child been seen in the Developmental Medicine Center before?	☐ Y ☐ N If yes, when? Was this for: ☐ a team visit ☐ an appointment with a single provider

*What languages are spoken in the home?	
*Where does the child live?	☐ at home ☐ away from home at residential facility or school
*Does your child require an interpreter to do the testing?	☐ Y ☐ N
*Does the parent/guardian require an interpreter for the visit?	☐ Y ☐ N

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***Do any of the following apply to this child?**

DCF (formerly DSS) involvement	☐ Y ☐ N
DDS (formerly DMR) involvement	☐ Y ☐ N
Lives in residential facility	☐ Y ☐ N

B. CONTACT / DEMOGRAPHIC INFORMATION

***Parent/Caregiver 1 information**

Full Name: Last ____ First ____

Relationship to child: ____

Home Street Address: ____

City: ____ State: ____ Zip: ____

Telephone (check preferred number): ☐ home ☐ work ☐ mobile

Email Address: ____

Occupation: ____

Are you the legal guardian of the child? ☐ Y ☐ N Do you have physical custody of child? ☐ Y ☐ N

Parent/Caregiver 2 information

Full Name: Last ____ First ____

Relationship to child: ____

Home Street Address: ____

City: ____ State: ____ Zip: ____

Telephone (check preferred number): ☐ home ☐ work ☐ mobile

Email Address: ____

Occupation: ____

Are you the legal guardian of the child? ☐ Y ☐ N Do you have physical custody of child? ☐ Y ☐ N

Legal Guardian information (if different from above)

Full Name: Last ____ First ____

Relationship to child: ____

Home Street Address: ____

City: ____ State: ____ Zip: ____

Telephone (check preferred number): ☐ home ☐ work ☐ mobile

Email Address: ____

Occupation: ____

Are you the legal guardian of the child? ☐ Y ☐ N Do you have physical custody of child? ☐ Y ☐ N

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C. SERVICES

CHECK if any of the following have previously or currently applies to your child

☐ Check here if your child is not yet in child care or school, and skip this table

Service			
Early Intervention	☐ Y, in the past	☐ Y, current	☐ N
Individualized Family Service Plan (IFSP)	☐ Y, in the past	☐ Y, current	☐ N
School (TEAM, CORE) evaluation *If yes, when?*	☐ Y, in the past	☐ Y, current	☐ N
Has/does your child have an Individualized Education Plan (IEP)? If yes, date?	☐ Y, in the past	☐ Y, current	☐ N
504 Plan *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
Attends a special needs daycare/preschool	☐ Y, in the past	☐ Y, current	☐ N
Receiving ☐speech ☐occupational ☐physical therapy	☐ Y, in the past	☐ Y, current	☐ N
Participates in Summer School or Extended School Year (ESY) services	☐ Y, in the past	☐ Y, current	☐ N
Psychological testing? *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
Mental health counseling or behavioral therapy? *If yes, date?*	☐ Y, in the past	☐ Y, current	☐ N
School disciplinary actions, including detention, suspension or expulsion? *If yes, specify & date?*	☐ Y, in the past	☐ Y, current	☐ N
Stay in psychiatric hospital	☐ Y, in the past	☐ Y, current	☐ N

****Please submit copies of the most recent Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), and results of any previous academic, psychological, or school testing from the past 3 years.**

<u>This information may be necessary for the Developmental Medicine Center to get authorization from your insurance company.</u>

D. CONCERNS YOU HAVE ABOUT YOUR CHILD'S DEVELOPMENT OR BEHAVIORS

*Please check **any concerns you have** about your child:

☐ Autism Spectrum Disorder (Asperger's, Autism, PDD) ☐ Attention problems (ADHD, ADD) ☐ Behavior problems ☐ Developmental delay ☐ Emotional or psychiatric problems ☐ Learning problem ☐ Social Skills ☐ Mood	☐ Intellectual disability (formerly mental retardation) ☐ Speech/language delay ☐ Communication problems ☐ Fine motor problem ☐ Gross motor problem ☐ Epilepsy/seizures ☐ Problems with coordination ☐ Ataxia ☐ Severe weakness or inability to tolerate exercise	☐ Tics/Tourette's ☐ Toileting problem (toilet training, bedwetting, soiling) ☐ Genetic or chromosomal condition ☐ Anxiety ☐ Obsessive-compulsive disorder (OCD) ☐ Bipolar disorder or mood swings ☐ Depression ☐ PTSD ☐ Substance use or abuse

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E. CHILD'S MEDICAL HISTORY

☐ Check if child's entire medical history is unknown – and answer as you are able.

Please check any conditions your child has been **diagnosed** with:

Developmental Problems:	**Mental Health Problems:**
☐ Speech delay ☐ Developmental Delay ☐ Behavior problems ☐ Autism ☐ Attention problems (ADD/ADHD) ☐ Learning problems	☐ Anxiety ☐ Obsessive Compulsive Disorder ☐ Mood Disorder (Depression, Bipolar, Suicide thoughts or attempts) ☐ Psychosis or Schizophrenia ☐ Child has had a stay in a psychiatric hospital *If yes, when/where?
Neurological Problems: ☐ Epilepsy/seizures ☐ Sleep problems ☐ Head injury ☐ Cerebral Palsy ☐ Tics or Tourette ☐ Motor delays ☐ Hearing problems ☐ Vision problems ☐ Headaches	**Genetic Disorders:** ☐ Down Syndrome/trisomy 21 ☐ Other chromosomal abnormalities ☐ Metabolic disorder
General Medical Problems: ☐ Heart disease ☐ Heart murmur ☐ Congenital heart problem ☐ Overweight/Obesity ☐ Growth problems ☐ Underweight/Failure to thrive ☐ Allergies ☐ Skin problems (rashes, eczema) ☐ Respiratory (asthma, pneumonia) ☐ Diabetes ☐ Thyroid ☐ Kidney/urinary problems ☐ Cancer ☐ Gastrointestinal problems (vomiting, feeding problems, abdominal pain, reflux, constipation, diarrhea)	**Surgical History:** Has your child ever had any surgeries? If yes, please list below: **Any other specific medical concerns?**

Has the child ever had any of the following screening/ diagnostic tests or procedures?		**If yes, when, where, and results? (Please send in copies of results if available)**
Genetic and/or metabolic testing	☐ Y ☐ N ☐ Don't know	
EEG	☐ Y ☐ N ☐ Don't know	
CT scan or MRI of the head	☐ Y ☐ N ☐ Don't know	
Sleep study	☐ Y ☐ N ☐ Don't know	
Hearing test	☐ Y ☐ N ☐ Don't know	
Vision test	☐ Y ☐ N ☐ Don't know	

***Review of Systems**

General/constitutional:	**Allergy:**
☐ Significant behavioral changes ☐ Significant weight loss or gain ☐ Weakness or fatigue ☐ Fever or chills	☐ Itchy or watery eyes ☐ Itchy or runny nose, sneezing ☐ Hives ☐ Needed to use Epi-Pen
Gastrointestinal: ☐ Changes in appetite ☐ Abdominal pain or discomfort ☐ Constipation ☐ Diarrhea ☐ Bloating, indigestion ☐ Nausea, vomiting ☐ Change in bowel habits (number/consistency) ☐ Blood in stool ☐ Jaundice (yellow skin or eyes), itching	**Neurological:** ☐ Headaches ☐ Dizziness, vertigo ☐ Weakness ☐ Seizures, convulsions ☐ Head injuries, concussions ☐ Trouble walking ☐ Tremor, unusual motor movement (tics) ☐ Problems with coordination ☐ Problems with concentration, memory ☐ Sleep problems ☐ Fainting, blackouts ☐ Numbness, tingling

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***Review of Systems (continued)**

Heart:	**Lungs:**
☐ Chest pain or pressure ☐ Heart racing, skipped beats ☐ Ankle swelling, cold/blue hands, feet ☐ Fainting, fatigue with exercise	☐ Cough ☐ Shortness of breath, wheezing ☐ Recent chest X-ray
Eyes, Ears, Nose, Throat: ☐ Sore throats ☐ Ear infections ☐ Sinus infections ☐ Loud snoring, irregular breathing during sleep ☐ Problems with eyes/vision ☐ Problems with ears/hearing	**Bones, joints, and muscles:** ☐ Joint pain, stiffness, swelling ☐ Fingers painful/blue in cold ☐ Dry mouth, red eyes ☐ Back, neck pain ☐ Muscle problems ☐ Fractures, broken bones ☐ Sprains
Endocrine: ☐ Sweating ☐ Fatigue ☐ Hand trembling ☐ Neck swelling ☐ Skin, hair, voice changes ☐ Thirst ☐ Growth difficulties	**Genitourinary:** ☐ Nighttime bedwetting ☐ Daytime urine accidents ☐ Pain with urination ☐ Frequent urination ☐ Blood in urine ☐ Genital rashes or lumps ☐ Heavy or painful menses (periods)
Skin: ☐ Rashes ☐ Changes in mole or spot ☐ Needed stitches	**Hematologic:** ☐ Bruise easily, difficulty stopping bleeding ☐ Lumps under arms or on neck

F. CHILD'S BIRTH HISTORY

☐ Check if birth history is unknown

Age of mother at delivery: ____________________

Age of father at delivery: ____________________

Number of previous pregnancies (including miscarriages or terminations): ____________

During pregnancy, did the mother:

Take prenatal vitamins	☐ Y ☐ N	
Use tobacco	☐ Y ☐ N	If yes: how much?
Drink alcohol	☐ Y ☐ N	If yes: how much?
Take drugs or medications	☐ Y ☐ N	If yes: what drug(s) or medication(s), and during which trimester(s):

Birth Measurements:	Weight: Height: Head Circumference:
APGAR score (if known):	1 minute: 5 minute:
Was the baby born at term?	☐ Y ☐ N or numbers of weeks gestation at birth:
What was the delivery method? *If cesarean, please describe why:*	☐ vaginal ☐ cesarean (C-section)
Were there any prenatal or neonatal complications? *If yes, please describe:*	☐ Y ☐ N
Was a NICU or extended hospital stay required? *If yes, please describe:*	☐ Y ☐ N

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G. CHILD'S DEVELOPMENTAL HISTORY

As best as you can remember, list the age or check off the approximate time at which your child reached the following developmental milestones.

Developmental Skill	Age (if known)	Not yet	*Only if exact age cannot be recalled*		
			Early	**At Normal Time**	**Late**
Sat without support		☐	☐	☐	☐
Crawled		☐	☐	☐	☐
Stood without support		☐	☐	☐	☐
Walked without assistance		☐	☐	☐	☐
Spoke first words		☐	☐	☐	☐
Said phrases		☐	☐	☐	☐
Said sentences		☐	☐	☐	☐
Bowel trained		☐	☐	☐	☐
Bladder trained, day		☐	☐	☐	☐
Bladder trained, night		☐	☐	☐	☐

****Please submit copies of the most recent Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), and results of any previous academic, psychological, or school testing from the past 3 years. <u>This information may be necessary for the Developmental Medicine Center to get authorization from your insurance company.</u>**

<u>PLEASE FEEL FREE TO ATTACH ANY ADDITIONAL INFORMATION THAT YOU THINK MIGHT HELP US BETTER UNDERSTAND YOUR CHILD.</u>

____________________ ____________________ ____________
*Parent/Guardian Signature *Print Name *Date

____
*Relationship to patient

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EARLY CHILDHOOD SCREENING ASSESSMENT:

Check the column that best describes this child compared to other children the same age. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
1. Seems sad, cries a lot	☐	☐	☐	☐
2. Is difficult to comfort when hurt or distressed	☐	☐	☐	☐
3. Loses temper too much	☐	☐	☐	☐
4. Avoids situations that remind him/her of scary events	☐	☐	☐	☐
5. Is easily distracted	☐	☐	☐	☐
6. Hurts others on purpose (biting, hitting, kicking)	☐	☐	☐	☐
7. Doesn't seem to listen to adults talking to him/her	☐	☐	☐	☐
8. Battles over food and eating	☐	☐	☐	☐
9. Is irritable, easily annoyed	☐	☐	☐	☐
10. Argues with adults	☐	☐	☐	☐
11. Breaks things during tantrums	☐	☐	☐	☐
12. Is easily startled or scared	☐	☐	☐	☐
13. Tries to annoy people	☐	☐	☐	☐
14. Has trouble interacting with other children	☐	☐	☐	☐
15. Fidgets, can't sit quietly	☐	☐	☐	☐
16. Is clingy, doesn't want to separate from parent	☐	☐	☐	☐
17. Is very scared of certain things (needles, insects)	☐	☐	☐	☐
18. Seems nervous or worries a lot	☐	☐	☐	☐
19. Blames other people for mistakes	☐	☐	☐	☐
20. Sometimes freezes or looks very still when scared	☐	☐	☐	☐
21. Avoids foods that specific feelings or tastes	☐	☐	☐	☐
22. Is too interested in sexual play or body parts	☐	☐	☐	☐
23. Runs around in settings when should sit still	☐	☐	☐	☐
24. Has a hard time paying attention to tasks or activities	☐	☐	☐	☐
25. Interrupts frequently	☐	☐	☐	☐
26. Is always "on the go"	☐	☐	☐	☐
27. Reacts too emotionally to small things	☐	☐	☐	☐
28. Is very disobedient	☐	☐	☐	☐
29. Has more picky eating than usual	☐	☐	☐	☐
30. Has unusual repetitive behaviors (rocking, flapping)	☐	☐	☐	☐
31. Might wander off if not supervised	☐	☐	☐	☐
32. Has a hard time falling asleep or staying asleep	☐	☐	☐	☐
33. Doesn't seem to have much fun	☐	☐	☐	☐
34. Is too friendly with strangers	☐	☐	☐	☐
35. Has more trouble talking or learning to talk than others	☐	☐	☐	☐
36. Is learning or developing more slowly than other children	☐	☐	☐	☐
Are you concerned about this child's emotional or behavioral development (please only circle one)?	☐ Yes	☐ Somewhat	☐ No	

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Please tell us how much of a problem each one has been for you. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
I feel too stressed to enjoy my child	☐	☐	☐	☐
I get more frustrated than I want to with my child's behavior	☐	☐	☐	☐
I feel down, depressed, or hopeless	☐	☐	☐	☐
I feel little interest or pleasure in doing things	☐	☐	☐	☐

Please summarize this child's OVERALL FUNCTIONING (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE option below. Compare this child's functioning in child care/school and with peers to "average children" his/her age that you are familiar with from you experience.
Please circle only one number.

☐	**Excellent** functioning/No impairment in settings
☐	**Good** functioning /Rarely shows impairment in settings
☐	**Mild** difficulty in functioning/Sometimes shows impairment in settings
☐	**Moderate** difficulty in functioning/Usually shows impairment in settings
☐	**Severe** difficulties in functioning/Most of the time show impairment in settings
☐	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
☐	**Needs 24-hour professional care and supervision** due to sever e behavior or gross impairment(s)

Have there been any other recent changes in your child's physical, emotional, psychological, or behavioral health that you are concerned about? Please describe:

*Parent/Guardian Signature

*Print Name

*Date

*Relationship to patient

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www.m-chat.org

Child's name ______________________ Date ______________________

Age ______________________ Relationship to child ______________________

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please check **yes** or **no** for every question. Thank you very much.

Question	Yes	No
1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	☐ Yes	☐ No
2. Have you ever wondered if your child might be deaf?	☐ Yes	☐ No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	☐ Yes	☐ No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	☐ Yes	☐ No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	☐ Yes	☐ No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	☐ Yes	☐ No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	☐ Yes	☐ No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	☐ Yes	☐ No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	☐ Yes	☐ No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	☐ Yes	☐ No
11. When you smile at your child, does he or she smile back at you?	☐ Yes	☐ No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	☐ Yes	☐ No
13. Does your child walk?	☐ Yes	☐ No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	☐ Yes	☐ No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	☐ Yes	☐ No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	☐ Yes	☐ No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	☐ Yes	☐ No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	☐ Yes	☐ No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	☐ Yes	☐ No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	☐ Yes	☐ No

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Early Childhood Educational Questionnaire

Child's Name: *Last ______________________ *First ______________________

*Date of Birth: ______________________ *Gender: ☐M ☐F ☐Other

Child' classroom/age level: ______________________

Please have early intervention, child care and/or school personnel fill out and return

Child Care/School: ______________________

Child Care/School address: ______________________

Form completed by: ______________________ Position: ______________________

With help from: ______________________

Contact Person: ______________________

Phone number and best time to call: ______________________

Email address ______________________

List up to 3 specific questions you would like answered as a result of this evaluation that would help you better meet this child's developmental and educational needs

1. ______________________
2. ______________________
3. ______________________

In your opinion, what areas of this child's functioning need the improvement?

Please describe the child's strengths.

Please describe any other concerns you have about this child.

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Besides English, are there any additional languages used for the child's instruction? ☐ Y ☐ N

If yes, what language? ______________________________

ACADEMIC READINESS: Please check the appropriate column

	Not Yet	Progressing	Proficient
A. Basic Concepts			
1. Knows colors	☐	☐	☐
2. Knows letters of alphabet	☐	☐	☐
3. Knows numbers and counts past 10	☐	☐	☐
4. Adds and subtracts things	☐	☐	☐
5. Size concepts	☐	☐	☐
6. Location concepts	☐	☐	☐
B. Language and Communication			
1. Uses speech to communicate	☐	☐	☐
2. Explains and describes things	☐	☐	☐
3. Rhymes words and remembers poems/songs	☐	☐	☐
4. Uses uncommon words	☐	☐	☐
5. Uses long sentences	☐	☐	☐
6. Tells or retells stories or events	☐	☐	☐
7. Speaks understandably	☐	☐	☐
8. Follows oral instructions on level with peers	☐	☐	☐
9. Uses correct grammar (e.g. verb tense)	☐	☐	☐
10. Uses sign language or other communication system	☐	☐	☐
11. Follows classroom routine	☐	☐	☐
C. Emergent Literacy			
1. Listens to stories in books	☐	☐	☐
2. Asks questions about words	☐	☐	☐
3. Reads words on signs and labels	☐	☐	☐
4. Reads words in books	☐	☐	☐
5. Recites books from memory	☐	☐	☐
6. Reads "easy" books	☐	☐	☐
7. Writes or copies words	☐	☐	☐
8. Dictates stories	☐	☐	☐
9. Writes "little" stories	☐	☐	☐
10. Answers questions about orally read story	☐	☐	☐
D. Motor Skills			
1. Constructs puzzles or builds things	☐	☐	☐
2. Uses pencils and pens correctly	☐	☐	☐
3. Uses scissors well	☐	☐	☐
4. Copies and traces shapes	☐	☐	☐
5. Draws recognizable objects	☐	☐	☐
6. Is coordinated in outdoor recess activities	☐	☐	☐
7. Ties shoe laces	☐	☐	☐

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EARLY CHILDHOOD SCREENING ASSESSMENT:

Please check the column that best describes this child compared to other children the same age. For each item, please check if you are concerned.

	Rarely/ Not True	Sometimes/ Sort of	Almost always/ Very True	Concerned?
1. Seems sad, cries a lot	☐	☐	☐	☐
2. Is difficult to comfort when hurt or distressed	☐	☐	☐	☐
3. Loses temper too much	☐	☐	☐	☐
4. Avoids situations that remind him/her of scary events	☐	☐	☐	☐
5. Is easily distracted	☐	☐	☐	☐
6. Hurts others on purpose (biting, hitting, kicking)	☐	☐	☐	☐
7. Doesn't seem to listen to adults talking to him/her	☐	☐	☐	☐
8. Battles over food and eating	☐	☐	☐	☐
9. Is irritable, easily annoyed	☐	☐	☐	☐
10. Argues with adults	☐	☐	☐	☐
11. Breaks things during tantrums	☐	☐	☐	☐
12. Is easily startled or scared	☐	☐	☐	☐
13. Tries to annoy people	☐	☐	☐	☐
14. Has trouble interacting with other children	☐	☐	☐	☐
15. Fidgets, can't sit quietly	☐	☐	☐	☐
16. Is clingy, doesn't want to separate from parent	☐	☐	☐	☐
17. Is very scared of certain things (needles, insects)	☐	☐	☐	☐
18. Seems nervous or worries a lot	☐	☐	☐	☐
19. Blames other people for mistakes	☐	☐	☐	☐
20. Sometimes freezes or looks very still when scared	☐	☐	☐	☐
21. Avoids foods with specific textures or tastes	☐	☐	☐	☐
22. Is too interested in sexual play or body parts	☐	☐	☐	☐
23. Runs around in settings when should sit still	☐	☐	☐	☐
24. Has a hard time paying attention to tasks or activities	☐	☐	☐	☐
25. Interrupts frequently	☐	☐	☐	☐
26. Is always "on the go"	☐	☐	☐	☐
27. Reacts too emotionally to small things	☐	☐	☐	☐
28. Is very disobedient	☐	☐	☐	☐
29. Has more picky eating than usual	☐	☐	☐	☐
30. Has unusual repetitive behaviors (rocking, flapping)	☐	☐	☐	☐
31. Might wander off if not supervised	☐	☐	☐	☐
32. Has a hard time falling asleep or staying asleep	☐	☐	☐	☐
33. Doesn't seem to have much fun	☐	☐	☐	☐
34. Is too friendly with strangers	☐	☐	☐	☐
35. Has more trouble talking or learning to talk than others	☐	☐	☐	☐
36. Is learning or developing more slowly than other children	☐	☐	☐	☐
Are you concerned about this child's emotional or behavioral development (please only circle one)?	☐ Yes	☐ Somewhat	☐ No	

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Please summarize this child's OVERALL FUNCTIONING (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE option below. Compare this child's functioning in child care/school and with peers to "average children" his/her age that you are familiar with from you experience.
Please circle only one number.

☐	**Excellent** functioning/No impairment in settings
☐	**Good** functioning /Rarely shows impairment in settings
☐	**Mild** difficulty in functioning/Sometimes shows impairment in settings
☐	**Moderate** difficulty in functioning/Usually shows impairment in settings
☐	**Severe** difficulties in functioning/Most of the time show impairment in settings
☐	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
☐	**Needs 24-hour professional care and supervision** due to sever e behavior or gross impairment(s)

Please describe this child's social-emotional functioning, including moods and relationship with peers.

Please describe this child's behavior.

Is there any other information you think would be helpful for evaluating this child?

*Teacher Signature *Print Name *Date

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