

ECHO Autism

Question of Autism

Case Presentation Form

TEAM: Justin Schwartz, MD; Laura Barefield, MD; Sarah O'Kelley, PhD; Susie Geerts, MS, RD, LD;
Lizzie Griffith, LGSW; Bama Hager, PhD; Tracy Cron, BSN

*Complete this form to the best of your ability and email to echoautism@peds.uab.edu or fax to
205-638-5089.*

Presenting Provider Name:

Clinic/Facility Name & City:

Provider Phone Number:

Provider Fax Number:

ECHO ID:

Presentation date:

Presentation Type:

Biological Gender:

Patient Age:

(Yrs)

(Mos)

Insurance:

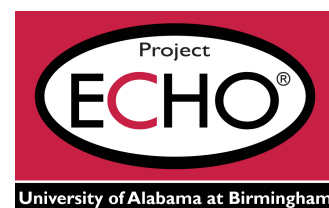
Insurance Company:

Race:

Ethnicity:

PLEASE NOTE: Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any ECHO Autism Collaborative clinician and any patient whose case is being presented in a Project ECHO® setting.

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What problem(s) would you like help with for your patient?

Does this child have an autism diagnosis?

If yes - Age at diagnosis:

Who made diagnosis?

Exposures during pregnancy

Smoking:

Alcohol:

Valproic Acid:

Street drugs/other:

Other:

Birth History

Gestational Age (weeks)

Birth weight:

Delivery mode:

Presentation:

If C-section, why?

Were there newborn problems?

If yes, explain:

Please check all of the following that apply:

In NICU

Required intubation

Seizures

Birth defects

Other

If Other, explain:

ECHO ID:

ECHO Autism

Developmental History

Check milestones the child has met:

Social Emotional Development/Play Skills

- Eye contact
- Interest in other kids
- Social Smile
- Range of emotions/facial expressions
- Joint attention
- Calms self
- Shared enjoyment
- Imitative play (clean, talk on phone)
- Imaginative play (play house, feed baby)

Communication Ability

- Non-verbal (no functional words)
- Uses single words
- Uses 2-3 word phrases
- Uses sentences
- Reciprocal conversation
- Chats with others
- Follows 1-2 step directions

Gross Motor Development

- Rolls over
- Crawls
- Walks
- Runs well
- Climbs
- Jumps
- Skips
- Catches ball

Check any Red Flags observed or reported

Social Emotional Red Flags

- Withdraws from others
- Limited/no interest in toys
- Limited/no pointing or use of non-verbal gestures (waving, pointing, signals "come here")
- Uses another person's hand as tool
- Difficulty accepting affection
- Prolonged or frequent "meltdowns"
- Upset by normal transitions
- Difficulty starting or maintaining peer relationships

Speech language Red Flags

- Delay in/lack of reciprocal babbling/cooing
- Repeats sounds or words (echolalia)
- Uses made-up language/jargon
- Does not respond to his/her name
- Loss of language
- Refers to self in third person
- Repeats phrases or lines

Sensory Concerns

- Sensitive to noise
- Avoids certain food textures
- Avoids certain clothing textures
- Smells non-food items
- Peers at objects at close range/corner of eye
- High pain tolerance

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Developmental History (continued)

Check milestones the child has met:

Fine Motor/Adaptive Development

- Pincer grasp
- Uses utensils
- Feeds self
- Helps with dressing
- Dresses self
- Buttons/unbuttons
- Age-appropriate handwriting
- Toilet Trained

Examples of developmental or behavioral concerns:

Check any Red Flags observed or reported

Repetitive/Stereotypic Behavior Red Flats

- Strong attachment to unusual objects
- Odd/unusual collections
- Gets stuck on topics/interest
- Continuous humming, jibber-jabber
- Rituals or unusual routines
- Hand flapping/finger flapping
- Spinning wheels or objects
- Repeats actions (light switches, opening doors)
- Spins, paces
- Lines items up
- Repetitive body movements

Behavior Concerns

- Anxious or worries
- Short attention span
- Hyperactivity
- Obsessive-compulsive
- Aggressive
- Hurting animals or other people
- Unusual or excessive fears
- Depression
- Defiant
- Self-injury (head banging, biting, scratching, cutting, picking, etc.)
- Toileting issues, accidents

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Developmental History (cont.)

Do parents share your concern?

Has there been **significant loss** of an acquired skill or skills?

Explain:

Medical/Psychiatric History: Please list all diagnoses or illnesses

How long has the child been in your care?

Diagnosis/Illness	Age	Date – Year	Professional making diagnosis
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Current Medications

Medication	Dosage	Age when started	Reason for medication	Is it helping?
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Please check all of the following that apply:

- | | | | |
|-----------------|--------------------------|------------------------|------------------------------|
| Seizures | Tic Disorder | Staring Spells | Hypotonia |
| Heart Problems | Hypertonia | Lung Problems | ADHD |
| Constipation | Toe Walking | Diarrhea | Environmental allergies |
| Nausea/vomiting | Stomach ache/pain/reflux | Chronic Ear Infections | Skin problems (rash, eczema) |

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Laboratory Test

Performed

Results

Chromosomal Microarray
 Karyotype
 Fragile X DNA
 MRI of the brain
 EG
 Sleep Study
 Lead Blood Level
 Audiologic (hearing) exam

Dietary/Nutrition/Metabolic

Current height:

Current weight:

Current head circumference
(if under 2)

Tracking height?

Tracking weight?

Please check all of the following that apply:

Problem eater

Picky eater

Special diet

Difficulty with solids

Difficulty with liquids

Eating/craving non-food items

Types and amounts of fluids:

Sleep History

Rarely = never or 1 time/week; **Sometimes** = 2-4 times /week; **Usually** = 5 or more times/week

Does child...?

How often?

Is it a problem?

Fall asleep within 20 minutes?

Co-Sleep

With whom?

Awaken more than once during the night?

Snore loudly

Seem tired during the day?

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Trauma/Abuse History

Trauma /serious accidents

Physical Abuse

Sexual Abuse

Social History

Who is living in the home?

Relationship (1/2 sib, step parent, etc.)

Age

Biological parents are:

Age

Gender

Siblings/Other Pregnancies

Include any miscarries, stillbirths, or babies that died

Family History

Condition/Disorder	Mom	Dad	Brother	Sister	Mat GM	Mat GF	Pat GM	Pat GF
Chromosome Disorders								
Autism Spectrum Disorder								
Intellectual disability								
Learning disability								
Seizure disorder (epilepsy)								
Mental Health Concerns								
Childhood deaths								
Birth Defects								
Dysmorphology								

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Educational History

Grade in School

Ever repeat a grade?

Are there learning problems? Please check all that apply:

Math

Reading

Writing

Explain

What best describes the child's current education program?

Full time in education regular class

Time split between regular and special education classes

Aide/Paraprofessional or extra help

Home School

Participation in Birth - 3 Early Intervention Programs

Early Childhood Special Education

Resources

Autism Society of Alabama

Behavioral Therapy/ABA

Easter Seals

Department of Human Resources (DHR)

Psychologist

Respite Care

WIC

Other:

Counseling

Help Me Grow Alabama

Speech Language Therapy (SLT)

Occupational Therapy (OT)

Physical Therapy (PT)

Social Security Disability (SSI)

Psychiatric Services

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