AUTISM SPECTRUM DISORDER REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH (NDDoH)
CHILDREN'S SPECIAL HEALTH SERVICES (CSHS)
SFN 60804 (9-2015)

Children's Special Health Services
600 E. Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200
701.328.2436 or 1.800.755.2714
Fax: 701.328.1645
Website: www.ndhealth.gov/cshs/autism.htm

Instructions: Within 30 days of diagnosis, complete the form in its entirety to notify the NDDoH of any case of autism spectrum disorder (ASD) as required by NDCC 23-01-41. Submit the form electronically or use a fillable pdf version that can be printed and returned to CSHS via mail or fax. This report can be found at: www.ndhealth.gov/cshs/autism.htm

REGISTRATION INFORMATION

☐ New ☐ Update

INSURANCE INFORMATION

Type of Insurance
☐ None ☐ Private ☐ Medicaid ☐ Medicare ☐ Tricare ☐ Other ☐ Unknown

INDIVIDUAL'S INFORMATION

Name as it Appears on Birth Certificate (Last, First, MI, Suffix)		Also Known As (Last, First, Middle, Suffix)		
Current Address		City	State	ZIP Code
County	Country	Social Security Number (optional) *	Telephone Number	

HOSPITAL/PLACE OF BIRTH

Place of Birth
☐ Clinic/Doctor's Office ☐ Freestanding Birthing Center ☐ Home Birth ☐ Hospital
☐ Other, Specify: _____

Name of Hospital/Place of Birth	County		
Country	City	State	ZIP Code

Birth Mother's Address At Time of Birth- if mother was institutionalized at time of birth (e.g., nursing home, prison, state hospital, etc.) enter mother's home address before she was institutionalized ☐ Same as individual's current address ☐ Unknown

Address	City	State	ZIP Code
County	Country		

PRIMARY CARE PROVIDER

Provider Name (Last, First) ☐ Unknown ☐ None	Practice/Facility Name		
Telephone Number	City	State	Country

BIRTH INFORMATION

Date of Birth	Sex ☐ Male ☐ Female ☐ Indeterminate	Birth Weight _____Grams -OR-_____ Lbs.,_____Oz. -OR- ☐ Unknown

Weeks of Pregnancy
☐ Early Term (between 37 weeks 0 days and 38 weeks 6 days) ☐ Full Term (between 39 weeks 0 days and 40 weeks 6 days)
☐ Late Term (between 41 weeks 0 days and 41 weeks 6 days) ☐ Post Term (between 42 weeks 0 days and beyond)
☐ Unknown

Plurality ☐ Single ☐ Twin ☐ Other Multiple ☐ Unknown	Mother's Age at Time of Delivery	Father's Age at Time of Delivery

Ethnicity Information

Hispanic/Latino
☐ Yes ☐ No ☐ Unknown

Primary Language Spoken in the Home
☐ English ☐ Spanish ☐ Other, Specify: _____

Race (check all that apply)

☐ White	☐ Chinese	☐ Other Asian	☐ Other Pacific Islander
☐ Black/African American	☐ Filipino	☐ Native Hawaiian	☐ Other, Specify: _____
☐ American Indian/Native Alaskan	☐ Korean	☐ Guamanian	☐ Refused/Unknown
☐ Asian Indian	☐ Vietnamese	☐ Samoan	

PARENT/GUARDIAN INFORMATION (A)

☐ Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Legal Guardian

Vital Status	Sex	Biologically Related to Individual
☐ Alive ☐ Dead ☐ Unknown	☐ Male ☐ Female	☐ Yes ☐ No ☐ Unknown

Name of Parent/Guardian (Last, First, Middle, Suffix)	Maiden Name		
Address ☐ Same as individual's current residence address	City	State	ZIP Code
Date of Birth / Telephone Number	County	Country	

Ethnicity Information

Hispanic/Latino
☐ Yes ☐ No ☐ Unknown

Race (check all that apply)

☐ White	☐ Chinese	☐ Other Asian	☐ Other Pacific Islander
☐ Black/African American	☐ Filipino	☐ Native Hawaiian	☐ Other, Specify: _____
☐ American Indian/Native Alaskan	☐ Korean	☐ Guamanian	☐ Refused/Unknown
☐ Asian Indian	☐ Vietnamese	☐ Samoan	

PARENT/GUARDIAN INFORMATION (B)

☐ Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Legal Guardian

Vital Status	Sex	Biologically Related to Individual
☐ Alive ☐ Dead ☐ Unknown	☐ Male ☐ Female	☐ Yes ☐ No ☐ Unknown

Name of Parent/Guardian (Last, First, Middle, Suffix)	Maiden Name		
Address ☐ Same as individual's current residence address	City	State	ZIP Code
Date of Birth / Telephone Number	County	Country	

Ethnicity Information

Hispanic/Latino
☐ Yes ☐ No ☐ Unknown

Race (check all that apply)

☐ White	☐ Chinese	☐ Other Asian	☐ Other Pacific Islander
☐ Black/African American	☐ Filipino	☐ Native Hawaiian	☐ Other, Specify: _____
☐ American Indian/Native Alaskan	☐ Korean	☐ Guamanian	☐ Refused/Unknown
☐ Asian Indian	☐ Vietnamese	☐ Samoan	

REPORTER/DIAGNOSTICIAN INFORMATION

Name of Individual Making Diagnosis (Last, First, Middle Initial)

Degree (select one)
☐ D.O. ☐ M.D. ☐ Psy.D. ☐ Ph.D. ☐ Masters ☐ Other, Specify: _____

Specialty

☐ Family Practice	☐ Neurology	☐ Psychology
☐ Internal Medicine	☐ Nursing (e.g. NP, CNS)	☐ Social Work (e.g. LICSW)
☐ Counseling (e.g. LPCC)	☐ Pediatrics	☐ Other, Specify: _____
☐ Clinical Genetics	☐ Psychiatry	

Practice/Facility Where Diagnosis Made			
Name of Practice/Facility	Department/Unit		
Current Address	City	State	ZIP Code
County	Country	Telephone Number	

Information on Person Submitting Report	
Relationship to Person Being Registered ☐ Reporter/Diagnostician ☐ Reporter's Designee	
Name (Last, First, Middle Initial)	Title ☐ Dr. ☐ Mr. ☐ Ms.

Contact information (if different from Reporter/Diagnostician)			
Name of Practice/Facility	Department/Unit		
Current Address	City	State	ZIP Code
County	Country	Telephone Number	

DIAGNOSTIC INFORMATION FOR REGISTRATION

Autism Spectrum Disorder History

Age at Diagnosis	Age Symptoms First Noted by Anyone
Years:_____ Months:_____ ☐ Unknown	Years:_____ Months:_____ ☐ Unknown

Diagnosis Information

Diagnosed with **DSM 5**

☐ Autism Spectrum Disorders (ASD)

Diagnosed with **DSM-IV** or **DSM-IV-TR**

☐ Asperger's Disorder ☐ Childhood Disintegrative Disorder ☐ Rett Syndrome

☐ Autistic Disorder ☐ Pervasive Developmental Disorder NOS

Diagnosed with **DSM-III** or **DSM-III-R**

☐ Infantile Autism ☐ Autistic Disorder

Other, Specify: _____

☐ No Longer Meets Criteria ☐ Never Met Criteria

Instruments/References Used (check all that apply)

- ☐ Adaptive Behavior Assessments (e.g., Vineland Adaptive Behavior Scales (VABS)
- ☐ Autism Behavior Checklist (ABC)
- ☐ Autism Diagnostic Interview-Revised (ADI-R)
- ☐ Autism Diagnostic Observation Schedule (ADOS)
- ☐ Autism Spectrum Rating Scale (ASRS)
- ☐ Childhood Autism Rating Scale (CARS)
- ☐ Intellectual/Cognitive Testing (e.g., Stanford-Binet Intelligence Scale (SBIS)
- ☐ Clinical Impressions
- ☐ Gilliam Aspergers Disorder Scale (GADS)
- ☐ Gilliam Autism Rating Scale (GAR)
- ☐ Modified Checklist for Autism in Toddlers, Revised (MCHAT-R)
- ☐ Pervasive Developmental Disorder Screening Test-II (PDDST-II)
- ☐ Social Communications Questionnaire (SCQ)
- ☐ Screening Tool for Autism in Two Year Olds (STAT)
- ☐ Social Responsiveness Scale (SRS)
- ☐ Other, Specify: _____

Diagnosed using **DSM-5**, indicate the levels of support needed for:

Restricted, Repetitive Behavior Severity Levels: (choose one)

- ☐ Level 3: "Requiring very substantial support"
- ☐ Level 2: "Requiring substantial support"
- ☐ Level 1: "Requiring support"

Social Communication Severity Levels: (choose one)

- ☐ Level 3: "Requiring very substantial support"
- ☐ Level 2: "Requiring substantial support"
- ☐ Level 1: "Requiring support"

CLINICAL IMPRESSIONS

PERSISTENT DEFICITS IN SOCIAL COMMUNICATION AND SOCIAL INTERACTION ACROSS MULTIPLE CONTEXTS

- ☐ Deficits in social-emotional reciprocity (e.g., reduced sharing of interests, emotions, or affect)
- ☐ Deficits in nonverbal communicative behaviors used for social interaction (e.g., abnormalities in eye contact and body language, poorly integrated verbal and nonverbal communication)
- ☐ Deficits in developing, maintaining, and understanding relationships (e.g., difficulties adjusting behavior to suit various social contexts, absence of interest in peers)

RESTRICTED, REPETITIVE PATTERNS OF BEHAVIOR, INTERESTS, OR ACTIVITIES

- ☐ Hyper or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., adverse response to specific sounds or textures)
- ☐ Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects)
- ☐ Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., rigid thinking patterns)
- ☐ Stereotyped or repetitive motor movements, use of objects, or speech (e.g., lining up toys or flipping objects, idiosyncratic phrases)

Was a **complete physical evaluation** done by a licensed independent practitioner as part of the diagnostic process for autism spectrum disorder in order to rule out conditions with similar symptoms?	☐ Yes	☐ No
Hearing Test Done	☐ Yes	☐ No
Have Excluded Organic Causes (e.g. Rett Syndrome, juvenile on-set schizophrenia, Encephalopathy, etc.)	☐ Yes	☐ No
Other, Specify: _____	☐ Yes	☐ No

Co-morbidities (check all that apply)

☐ ADHD	☐ GERD or other Gastro Conditions	☐ Oppositional Defiant Disorder
☐ Asthma	☐ Hydrocephalus	☐ Schizophrenia
☐ Depression/Bipolar/Mood	☐ Intellectual Disability	☐ Seizures/Epilepsy
☐ Feeding/Eating Disorders	☐ Microcephaly/Macrocephaly	☐ Sleep Disorders
☐ Fetal Alcohol Syndrome	☐ Obesity	☐ Tic Disorders
☐ Genetic Disorders	☐ Obsessive Compulsive Disorder	☐ Other, Specify: _____

Medication(s) Use

	Current	Former
Alpha-agonist (e.g., Clonidine, Doxazosin, Prazosin)	☐	☐
Anticonvulsants (e.g., Depakote, Lamictal)	☐	☐
Antidepressants (e.g., Lexapro, Prozac, Zoloft)	☐	☐
Anxiolytics (e.g., Ativan, Buspar)	☐	☐
CAMs (e.g., acupuncture, massage therapy, yoga)	☐	☐
Neuroleptics (e.g., Abilify, Risperdal, Seroquel)	☐	☐
Non-stimulants (e.g., Intuniv, Strattera)	☐	☐
Nutritional Supplements (e.g., herbs, minerals, vitamins)	☐	☐
Sleep Aid (e.g., Ambien, Lunesta)	☐	☐
Stimulants (e.g., Adderall, Ritalin, Dexedrine)	☐	☐
Other, Specify: _____	☐	☐

SIBLING INFORMATION

Have any siblings been diagnosed with Autism Spectrum Disorder?
☐ Yes ☐ No - If yes, how many? _____

EACH SIBLING WITH AUTISM SPECTRUM DISORDER DIAGNOSIS SHOULD BE REGISTERED ON A SEPARATE FORM

* The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect reporting into the database.