AUTISM SPECTRUM DISORDER REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH (NDDoH)
OFFICE OF THE STATE EPIDEMIOLOGIST
SFN 60804 (4-2018)

Office of the State Epidemiologist
600 E. Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200
701.328.4832 or 1.800.755.2714
Fax: 701.328.2785
Website: www.ndhealth.gov/cshs/autism.htm

Instructions: A mandatory reporter or the reporter's designee must report newly diagnosed individuals to the NDDoH within 30 days of diagnosis. Previously diagnosed individuals must be reported to the NDDoH within 30 days of the individual's first patient or client encounter with the reporter. The form must be completed in its entirety as required by NDCC 23-01-41.

INFORMATION ON PERSON SUBMITTING REPORT FORM

Name of the Reporter (Last, First, MI)		Telephone Number	
Name of the Reporter's Practice/Facility	City	State	ZIP Code

REGISTRATION INFORMATION

Today's Date	Registration Type	Has the individual or the Parent/Guardian been informed of reporting requirements?
	☐ New ☐ Update to previously reported information	☐ Yes ☐ No

INFORMATION OF INDIVIDUAL DIAGNOSED WITH ASD

Name (Last, First, MI)	Date of Birth	Sex	
		☐ Male ☐ Female ☐ Indeterminate	
Address	City	State	ZIP Code
County		Telephone Number	☐ Home ☐ Cell
Race (Check all that apply) ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ American Indian/Native Alaskan ☐ Other (specify): _____		Hispanic/Latino ☐ Yes ☐ No ☐ Refused ☐ Unknown	

PARENT/GUARDIAN INFORMATION IF INDIVIDUAL IS UNDER THE AGE OF 18

Name of Parent **A** (Last, First, MI		Telephone Number	☐ Home ☐ Cell
Address (Street) ☐ Same as the reported individual's address	City	State	ZIP Code
Name of Parent **B** (Last, First, MI		Telephone Number	☐ Home ☐ Cell
Address (Street) ☐ Same as the reported individual's address	City	State	ZIP Code

INSURANCE INFORMATION

☐ None ☐ Private ☐ Medicaid ☐ Medicare ☐ Tricare ☐ Other (specify): _____ ☐ Unknown

DIAGNOSTIC INFORMATION

☐ Diagnosed with Autism Spectrum Disorders (ASD)

If previously diagnosed, specify type:

- ☐ Autistic Disorder
- ☐ Pervasive Developmental Disorder NOS
- ☐ Asperger's Disorder

Update to Diagnostic Information

- ☐ Never met ASD criteria
- ☐ Deceased, Date of Death: _____

Date of Diagnosis (M/D/Y)

Age at Diagnosis
☐ Unknown
_____ Yrs. ☐ < 12 months

Screening/Diagnostic Tools 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 Schedules (ADOS)
- ☐ Autism Spectrum Rating Scale (ASRS)
- ☐ Childhood Autism Rating Scale (CARS)
- ☐ Childhood Autism Spectrum Test (CAST)
- ☐ Clinical Impressions
- ☐ Intellectual/ Cognitive Testing (e.g., Stanford-Binet Intelligence Scale (SBIS))
- ☐ Gilliam Autism Rating Scale (GAR)
- ☐ Modified Checklist for Autism in Toddlers (M-CHAT)
- ☐ Social Responsiveness Scale
- ☐ Other (specify): _____
- ☐ Unknown

ASD Diagnosis was Made:

☐ Independently by a single provider ☐ Interdisciplinary/multidisciplinary team approach ☐ Other (specify): _____ ☐ Unknown

Were the following evaluations done by a licensed independent practitioner as part of the diagnostic process for ASD?

Physical Evaluation Completed	☐ Yes	☐ No	☐ Unknown
Hearing Test Done	☐ Yes	☐ No	☐ Unknown
Have Excluded Organic Causes	☐ Yes	☐ No	☐ Unknown

Co-morbidities (check all that apply)

☐ ADHD/ADD	☐ Fragile X Syndrome	☐ Obsessive Compulsive Disorder	☐ Tourette Syndrome/Tic Disorders
☐ Anxiety	☐ Gastorintestinal Symptoms (e.g., GERD)	☐ Oppositional Defiant Disorder	☐ Tuberous Sclerosis
☐ Bipolar Disorder	☐ Immune Disorders	☐ Schizophrenia	☐ Other (specify): _____
☐ Depression	☐ Intellectual disability	☐ Seizures/Epilepsy	☐ None
☐ Down Syndrome	☐ Microcephaly/Macrocephaly	☐ Sensory Processing Disorders	☐ Unknown
☐ Feeding/Eating Disorders	☐ Obesity	☐ Sleep Disorders	

DIAGNOSTICIAN INFORMATION

Name of the Diagnostician (Last, First, MI) ☐ Unknown

Degree of Diagnostician (Select One)
☐ M.D. ☐ D.O. ☐ Psy.D. ☐ Ph.D. ☐ Masters

Specialty of Diagnostician

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

Name of Diagnostician's Practice/Facility	City	State

BIRTH INFORMATION

Birth Weight
_____ Lbs., _____ Oz. ☐ Unknown

Plurality
☐ Single ☐ Twin ☐ Other Multiple ☐ Unknown

Hospital/Place of Birth

City	State	ZIP Code	Mother's Age at Time of Delivery	Father's Age at Time of Delivery

Weeks of Pregnancy

☐ Early Term (between 37 weeks 0 days and 38 weeks 6 days)	☐ Post Term (between 42 weeks 0 days and beyond)
☐ Late Term (between 41 weeks 0 days and 41 weeks 6 days)	☐ Other (specify): _____
☐ Full Term (between 39 weeks 0 days and 40 weeks 6 days)	☐ Unknown

Have Any Siblings Been Diagnosed with ASD?
☐ Yes, how many: _____ ☐ No ☐ Unknown

EACH SIBLING WITH AN ASD DIAGNOSIS SHOULD BE REGISTERED ON A SEPARATE FORM

SERVICE UTILIZATION

Age Symptoms First Noted by Anyone
_____Yrs -OR- ☐ Less than 12 months-OR- ☐ Unknown

Age When Services First Started
_____Yrs -OR- ☐ Less than 12 months-OR- ☐ Unknown

What Services Have Been Utilized (mark all that apply)

☐ ASD Medicaid Waiver	☐ Home and Community Based Services (HCBS)/Developmental Disabilities (DD) Waiver	☐ 504 Plan
☐ ASD Services Voucher Program		☐ Other (specify): _____
☐ Early Intervention Program (e.g., Right Track Infant Development)	☐ Special Education Services (e.g., IEP)	☐ Unknown
☐ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (e.g., Health Tracks)	☐ Therapy (specify): _____	☐ None

If ***None***, Why Not

☐ Aged out before services could be utilized	☐ Didn't qualify for services	☐ On waiting list	☐ Unknown
☐ Didn't know about available services	☐ Didn't need services	☐ Currently being referred	☐ Other (specify): _____

BEHAVIOR/RISK ASSESSMENT

At the time of submission has the individual had any of the following behaviors

☐ Aggressiveness towards others ☐ Wandering/elopement ☐ No ☐ Unknown

☐ Self-injurious behavior (e.g., head banging, punching or hitting oneself, hand/arm biting, picking at skin or sores, swallowing dangerous substances or objects, and excessive rubbing or scratching)

At the time of submission has the individual ever been admitted to any of the following because of the previously listed behaviors?

☐ Psychiatric Residential Treatment Facility ☐ Residential Care Facility ☐ Emergency Department/Emergency Room ☐ No ☐ Unknown