



Center for Development & Disability

2300 Menaul Blvd., N.E.
Albuquerque, NM 87107

*Autism and other Developmental
Disabilities' Programs Division*
Parent Home Training Program

Phone: (505) 272-4725

Fax: (505) 272-3140

Contact Information and Preferences

Name: _____

Home Phone: _____

Cell phone: _____

Work phone: _____

E-mail address: _____

Please indicate how you would like to be contacted (Select all that are applicable):

Home Phone

Cell phone

Work phone

E-Mail

Best time of day to be contacted (Select all that are applicable):

Morning (8 am - 11 am)

Early Afternoon (11 am - 2 pm)

Afternoon (2 pm - 5 pm)

Evening (5 pm - 8 pm)



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For use by CDD staff only:

Referral Date: _____

Autism Client #: _____

Intake Date: _____

Childs Initials: _____

How did you hear about the Parent Home Training Program?

Where and when was your child diagnosed with an autism spectrum disorder?

When did you first become concerned about your child's development?

Family History

What languages are used in your child's home?

Who lives in your child's home?

Does anyone else regularly provide care for your child?

Has your child recently been impacted by any major family changes?

Adoption	Y	N	Moving	Y	N
Serious Illnesses	Y	N	Domestic Violence	Y	N
Foster Care	Y	N	Divorce	Y	N
Remarriage	Y	N	Substance Abuse	Y	N

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Does anyone in the child's immediate family have any developmental problems?

Does anyone in the child's immediate family have any mental health or psychiatric issues?

Education

Does your child currently receive educational/therapeutic services from and of the following?

An early intervention program Y N A school program Y N

If so, what services does your child receive and how often does he/she receive them?

Current Concerns

Do you have any concerns about your child's communication? How does your child currently communicate with you?

Do you have any concerns about your child's behavior? If so, what are your concerns?

How does your child play and get along with others?



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Does your child display any sensory concerns? Does your child seem over or under responsive to certain stimuli?

Have you started toilet training yet?

Are there any other concerns that you would like to share?

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Medical Concerns

Does your child have any medical diagnoses other than an autism spectrum disorder?

Is your child currently on medication? (If so please list with milligrams)

Has your child ever had any of the following?

Hospitalization	Y	N	Seizures	Y	N
Allergies	Y	N	Significant Illnesses	Y	N
Injuries	Y	N	Vision problems	Y	N
Hearing problems	Y	N	Sleeping problems	Y	N
Eating problems	Y	N			

Please describe any items marked "Yes" below:

**PLEASE INCLUDE ANY ON HAND/AVAILABLE COPIES OF YOUR CHILD'S IFSP'S
OR IEP'S AND ANY OTHER MEDICAL, SCHOOL OR THERAPY REPORTS**

Please send or scan and email your completed application to:
University of New Mexico HSC
The Autism Programs Center for Development and Disabilities' Division
Parent Home Training Program
2300 Menaul NE
Albuquerque, New Mexico 87107

**Your family will be placed on the waiting list as soon as we receive your application, so
please do not delay.**

If you have any questions about this application or this program, please contact
Sylvia Acosta 505-272-4725 or SyAcosta@salud.unm.edu