Autism Spectrum Evaluation Clinic: Instructions and Checklist

Please keep this checklist for your records

Thank you for contacting the Center for Development and Disability Autism Spectrum Evaluation Clinic. Our program provides comprehensive, team evaluations for Autism Spectrum Disorder and other developmental disabilities for children three years and older.

Please provide the following information to prepare the team for your child’s evaluation. CDD-UNMMG consent forms must be signed by the client’s legal guardian.

- **CDD Child Information Form** (3 pages)
- **Autism Spectrum Evaluation Clinic-Child Information Addendum** (4 pages)
- **CDD Consent to Treat** form signed by legal guardian
- **Patient Registration** form including insurance information
- **Race and Ethnicity** form signed by legal guardian
- **Teacher Questionnaire**
- Copies of any previous developmental or medical reports
- Copies of school records, including any special education evaluations or current Individualized Educational Program (IEP) reports.

If you would like our staff to request records, please complete one **Authorization to Request Health Information** form for each school or agency.

Your child will be added to our waiting list when the packet is received. We will send you a confirmation letter, with an estimate of when you may expect to be scheduled. Please note, that currently our waiting list is **twelve to sixteen months**.

Fax or mail completed packet to:

Center for Development and Disability
Clinical Services - Autism
2300 Menaul Blvd, NE.
Albuquerque, NM 87107
Fax# 505.272.2014
Child Information
Please complete all sections

INTAKE INFORMATION
Who is completing this form? __________________________________________ Name and relationship to child

Today's date: ________________________

Who is referring? __________________________________________ Name and relationship to child

Referrer’s phone: ________________________

CHILD'S INFORMATION
Name:________________________________________ Date of birth: _______________________________________________________________________

Sex: M   F

Primary language: __________________________ Other languages: _______________________________________________________________________

PEDIATRICIAN / PRIMARY CARE PROVIDER
Name: __________________________________________

Phone: __________________________________________ Fax: __________________________________________

Address: __________________________________________

PARENTS/CAREGIVERS
Are the Parents the legal guardians for this child?   □ Yes   □ No

1. Name: __________________________________________ Relationship: _______________________________________________________________________

Email address: __________________________________________ Mailing address: _______________________________________________________________________

Phone: __________________________________________ Fax: __________________________________________

1. Name: __________________________________________ Relationship: _______________________________________________________________________

Email address: __________________________________________ Mailing address: _______________________________________________________________________

Address: __________________________________________

Legal Guardians, Foster Parents or Other Caregivers:

1. Name: __________________________________________ Relationship: _______________________________________________________________________

Email address: __________________________________________ Mailing address: _______________________________________________________________________

Phone: __________________________________________ Fax: __________________________________________

1. Name: __________________________________________ Relationship: _______________________________________________________________________

Email address: __________________________________________ Mailing address: _______________________________________________________________________

Phone: __________________________________________ Fax: __________________________________________

Is the Children, Youth and Families Department (CYFD), or other protective service agency, involved with the child or family?   □ Yes   □ No

If yes, please provide the CYFD Social Worker or contact:

Name: __________________________________________ Phone: __________________________________________ Email: __________________________________________ Fax: __________________________________________
Who lives in the home with the child?

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to Child</th>
<th>Primary Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
<td></td>
<td></td>
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<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If English is not the native language for yourself or your child, will an interpreter be needed for the evaluation?

- [ ] Yes  
- [ ] No

If yes, what language?

SERVICE PROVIDER INFORMATION

Is the child currently in intervention services? (For example: early intervention, school, other therapy services, etc.)

- [ ] Yes  
- [ ] No

Please provide the following information regarding current intervention services:

<table>
<thead>
<tr>
<th>Therapist</th>
<th>Name</th>
<th>Agency/School</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Language Pathologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker/Counselor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CONCERNS / QUESTIONS

Check all boxes below that best describe the nature of your concern(s):

- [ ] Accidents / Injuries  
- [ ] Epilepsy / Seizures  
- [ ] Prenatal Exposures
- [ ] Allergies             
- [ ] Family Stressors      
- [ ] Sensory / Regulation
- [ ] Asthma                
- [ ] Feeding / Nutrition   
- [ ] Sleep
- [ ] Attention             
- [ ] Hearing               
- [ ] Special Equipment
- [ ] Autism Spectrum Disorder  
- [ ] Learning / Thinking   
- [ ] Speech / Language
- [ ] Behavioral Difficulties 
- [ ] Medical / Health      
- [ ] Vision
- [ ] Coordination / Balance 
- [ ] Motor (Use of arms/legs) 
- [ ] Other: ________________
- [ ] Coordination / Balance 
- [ ] Motor (Use of arms/legs) 
- [ ] Other: ________________
- [ ] Ear Infections        
- [ ] Premature / Complex Birth
Child's Name: _________________________________________________________________ MRN:_______________________________________

Please explain your concerns or questions: _______________________________________________________________

___________________________________________________________________________________________________

What do you hope to gain from this evaluation? ______________________________________________________________

___________________________________________________________________________________________________

What does the child do well? ________________________________________________________________

___________________________________________________________________________________________________

What activities does the child enjoy? ________________________________________________________________

___________________________________________________________________________________________________

MEDICAL/DEVELOPMENTAL INFORMATION

When was child’s most recent hearing screening/test? __________ Results? Pass Fail

When was child’s most recent vision screening/test? __________ Results? Pass Fail

Does the child have medical, behavioral, and/or developmental diagnoses? (For example: Fragile X, ADHD, seizure disorder, Autism Spectrum Disorder, etc.): □ Yes □ No

If yes, please list: _____________________________________________________________________________________

___________________________________________________________________________________________________

Does the child take medication? □ Yes □ No

If yes, please list: _____________________________________________________________________________________

___________________________________________________________________________________________________

When did the child first do the following:

<table>
<thead>
<tr>
<th>Skill</th>
<th>Age</th>
<th>Not Yet</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolled over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sat without help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crawled on hands and knees</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Walked without help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Said single words</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put two or more words together (e.g., &quot;green car&quot;)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Talked in short sentences (e.g., &quot;Daddy has a green car&quot;)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet trained (during the day)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet trained (overnight)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did the child ever lose any of the above skills? □ Yes □ No

If yes, please describe: _____________________________________________________________________________

___________________________________________________________________________________________________

Please feel free to attach any additional information that you would like to provide.
Autism Spectrum Evaluation Clinic  
Child Information Addendum  
_Please complete all sections - 4 pages_

Child’s Name: ________________________________

**FAMILY MEDICAL HISTORY**

Is there any history of developmental or behavioral issues in the child’s immediate family? Please check all that apply.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mother</th>
<th>Father</th>
<th>Sibling</th>
<th>Grandparent</th>
<th>Other (Aunts, Uncles, Cousins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Developmental Delays</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Neurological Problems</td>
<td></td>
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<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
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<tr>
<td>Alcohol or Substance Abuse</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Other mental health or behavior issues</td>
<td></td>
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</tbody>
</table>
**CHILD MEDICAL HISTORY**

Were there any problems or complications during pregnancy? □ Yes □ No
If yes, please explain:

<p>| | | |</p>
<table>
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</table>

If the child’s mother used any of the following during the pregnancy, please check and describe.

- [ ] Vitamins or Supplements
- [ ] Prescription Medications
- [ ] Tobacco
- [ ] Alcohol
- [ ] Other drugs

Were there any problems or complications during delivery? □ Yes □ No
If yes, please explain:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tbody>
</table>

Was the child born on time? □ Yes □ No  Weeks Early _____ Weeks Late _______
Type of Delivery: ___________________________  Birth Weight: _______________________

Were there any problems, complications or hospitalizations after birth? □ Yes □ No
If yes, please explain:

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</table>

Please describe the child’s temperament/personality during the first few months:

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</table>
Has the child been affected by any of the following? Check any that apply
If yes, please note age and explain each checked area.

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Concern for Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Significant Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Medical studies or specialist consults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Sleep concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Feeding/diet concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other concerns (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other concerns (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list all medical diagnoses your child has been given, with age, date, and provider who made the diagnosis.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Age</th>
<th>Date</th>
<th>Provider/Agency</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Please list any medications the child takes currently:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Has the child been affected by any of the following? Please check any that apply, and explain each checked area.

- ☐ Adoption
- ☐ Foster care
- ☐ Domestic violence
- ☐ Physical or sexual abuse
- ☐ Divorce/remarriage
- ☐ Drug or alcohol use
- ☐ Serious family illness
- ☐ Household moves
- ☐ Other concerns (please specify)

**EDUCATIONAL SERVICES**

Has the child ever received special education services in school?

- ☐ Never requested/referred
- ☐ Denied eligibility
- ☐ Waiting for evaluation
- ☐ Has current IEP
- ☐ Had IEP in the past, not now

When was the child last tested for special education services?

Date:______________  Age:______________  Grade:_______

Please include copies of previous evaluations or treatment records, if available:

- Reports for any school evaluations
- Current Individualized Educational Program report
- Behavioral health assessments (e.g., psychology, social work)
- Reports from medical specialists (e.g., genetics, neurology)

If you would like our staff to request records directly from other providers, schools or agencies, please complete and sign “Authorization to Release Health Information” forms.

*Please feel free to attach any additional information that you would like to provide.*
Center for Development and Disability

Consent to Treatment and Assignment of Benefits

1. I, the undersigned, hereby request and consent to medical treatment by the Center for Development and Disability or UNM Medical Group, Inc. and its physicians and staff (including administration of medication, tests and procedures) as deemed necessary.

2. I hereby assign and request payment directly to the Center for Development and Disability and UNM Medical Group, Inc. of any insurance or other authorized health benefits otherwise payable to me for medical treatment rendered, and to release any information required to the insurance company for consideration of payment for services.

______________________________   ________________________________
Signature of Patient or Representative                  Date

______________________________   ________________________________
Printed Name of Patient or Representative                  Relationship to Patient

Revised: 8/2014
**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name (Last, First, MI)</td>
<td>___________________________</td>
</tr>
<tr>
<td>DOB:</td>
<td>___________</td>
</tr>
<tr>
<td>Address:</td>
<td>___________________________</td>
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<tr>
<td>Phone:</td>
<td>___________________________</td>
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<tr>
<td>City:</td>
<td>___________________________</td>
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<tr>
<td>State:</td>
<td>_______</td>
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<tr>
<td>Zip:</td>
<td>_______</td>
</tr>
<tr>
<td>Tribe:</td>
<td>___________________________</td>
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<tr>
<td>Patient's SSN:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Sex: M F</td>
<td>___________________________</td>
</tr>
<tr>
<td>Race/Ethnicity:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Patient's Marital Status:</td>
<td>___________________________</td>
</tr>
<tr>
<td>If Married, Name of Spouse:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Patient's Employment Status:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Occupation:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Employer Name:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Employer Phone:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Employer Address:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Email Address:</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

**PARENT / GUARDIAN (IF PATIENT IS A MINOR)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Relationship:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Address:</td>
<td>___________________________</td>
</tr>
<tr>
<td>City:</td>
<td>___________________________</td>
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<tr>
<td>State:</td>
<td>_______</td>
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<tr>
<td>Zip:</td>
<td>_______</td>
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<tr>
<td>Phone:</td>
<td>___________________________</td>
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</tbody>
</table>

**NEXT OF KIN / EMERGENCY CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Relationship:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Address:</td>
<td>___________________________</td>
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<tr>
<td>City:</td>
<td>___________________________</td>
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<tr>
<td>State:</td>
<td>_______</td>
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<tr>
<td>Zip:</td>
<td>_______</td>
</tr>
<tr>
<td>Phone:</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

**REFERRING PHYSICIAN**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Phone/Fax:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Address:</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

**INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is patient covered under Medicare/Medicaid?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>If yes, Medicare/Medicaid #:</td>
<td>___________________________</td>
</tr>
<tr>
<td>If covered under Medicaid, which salud? (please circle)</td>
<td>Molina / BCBS / Lovelace / Presbyterian</td>
</tr>
<tr>
<td>Is patient covered under Insurance? (please circle)</td>
<td>Yes / No</td>
</tr>
<tr>
<td>If yes, please provide the following:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Policy holder's Name:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Policy holder's DOB:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Policy holder's SSN:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Relationship to Patient:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Insurance Company:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Phone:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Address:</td>
<td>___________________________</td>
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<tr>
<td>Group #:</td>
<td>___________________________</td>
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<tr>
<td>Policy #:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Authorization #:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Policy holder's Employer:</td>
<td>___________________________</td>
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<tr>
<td>Occupation:</td>
<td>___________________________</td>
</tr>
<tr>
<td>Employer Address:</td>
<td>___________________________</td>
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<tr>
<td>City:</td>
<td>___________________________</td>
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<tr>
<td>State:</td>
<td>_______</td>
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<tr>
<td>Zip:</td>
<td>_______</td>
</tr>
<tr>
<td>Telephone:</td>
<td>___________________________</td>
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</tbody>
</table>
Dear Patient,

UNM Medical Group Inc. wants to give you the best, safest health care possible! Your answers to these questions help us make sure we meet your needs and give the best, safest health care to all patients. Your answers will remain private. Access to this information is very restricted. Thank you!

Do you consider yourself Hispanic or Latino?
- [ ] Yes
- [ ] No
- [ ] Don’t want to answer

What is your race? **PICK ONE.**
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or other Pacific Islander
- [ ] White or Anglo
- [ ] Two or more races
- [ ] Don’t want to answer

If you are American Indian/Native American, what tribe(s) or pueblo(s)?
- [ ] Navajo
- [ ] Pueblo: __________________
- [ ] Other: __________________
- [ ] Other: __________________

What is your religion or spirituality?
- [ ] Baptist
- [ ] Buddhist
- [ ] Catholic
- [ ] Christian: __________________
- [ ] Jehovah’s Witness
- [ ] Jewish
- [ ] Latter-Day Saints/Mormon
- [ ] Muslim
- [ ] Native Traditional
- [ ] Protestant: __________________
- [ ] Other: __________________
- [ ] None
- [ ] Don’t want to answer

What is your relationship status?
- [ ] Single
- [ ] Legally married
- [ ] Domestic partnership/civil union
- [ ] Partnered, living together
- [ ] Partnered, not living together
- [ ] Divorced/permanently separated
- [ ] Widowed/separated by death
- [ ] Other: __________________

If you do not speak English well, you have the right to a free interpreter. We will provide one for you. In what language do you prefer to **talk** about your health care? **PICK ONE.**
- [ ] English
- [ ] Spanish
- [ ] Vietnamese
- [ ] Navajo
- [ ] Other: ______________

In what language do you prefer to **read** about your health care? **PICK ONE.**
- [ ] English
- [ ] Spanish
- [ ] Vietnamese
- [ ] I need help with reading
- [ ] None
- [ ] Other: ______________

Patient signature: _____________________________
Date: _____________________________

Thank you! If you have questions, please ask our staff.

(1) Enter data into Cerner,
(2) Place reg sticker here
(3) send form to ILS 2-5399
AUTISM SPECTRUM EVALUATION CLINIC
TEACHER QUESTIONNAIRE

We are evaluating one of your students in the Autism Spectrum Evaluation Clinic at the University of New Mexico Center for Development and Disability. Your input and comments are invaluable for this process. The family has been requested to have this form completed prior to the child’s clinic appointment. If more than one teacher wishes to complete a report, please feel free to xerox and send multiple copies. Please add any additional information that you feel may be helpful.

Child’s Name: ________________________________ Date: __________________

Teacher: ___________________________ Name of School: _________________________
Address ___________________________________________________________________
Grade _______________ Type of Class _______________________________________
Number of students in class _______________ (including regular and special education)
Number of teachers and aides __________________________________________________

How well do you know this student (please circle your response). How long? ___________

Very well         Moderately well        Not very well

Does this student have an IEP? ________ Category of eligibility?_____________________

Please list your major concerns about this student:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What are this student’s strengths?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

How does this student interact with the other students in your class?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Specific questions, concerns and/or areas you would like help with this child:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Thank you for your time. Please return this form directly to parents to send as part of the UNM Autism Spectrum Evaluation Clinic intake packet.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ___________________________  Date of Birth: _______  Medical Record #: __________________

1. I hereby authorize ____________________________________________________________ ____________________________
   (Name of Disclosing Party)          (Phone/Fax of Disclosing Party)
   (Address, City, State, Zip of Disclosing Party)

To Disclose to:

☐ UNM Center for Reproductive Health
   1701 Moon NE, Suite 200
   Albuquerque, NM 87131
   505-925-4455

☐ UNM Cardiology Clinic McMahon
   4824 McMahon Blvd NW, Suite 109
   Albuquerque, NM 87114
   505-925-6001

☐ UNM Center for Development and Disability
   2300 Menaul Blvd NE
   Albuquerque, NM 87107
   505-272-3000

☐ UNM Dental Services @ Camino de Salud Residency Clinic
   1801 Camino de Salud, Suite 1200
   Albuquerque, NM 87102
   505-925-4031

☐ UNM Dental Services @ Novitski Hall
   2320 Tucker NE
   Albuquerque, NM 87131
   505-272-4106

☐ UNM Dental Services @ Carrie Tingley
   1127 University Blvd, NE
   Albuquerque, NM 87106
   505-272-5326

☐ UNM Center for Life
   4700 Jefferson Blvd. NE, Suite 100
   Albuquerque, NM 87109
   505-925-7464

☐ UNM Truman Health Services
   801 Encino Place NE, Bldg F
   Albuquerque, NM 87102
   505-272-1312
   Please Fax Request to: 505-272-2240

☐ UNM Vein and Cosmetic Center
   7007 Wyoming Blvd NE, Suite A-3
   Albuquerque, NM 87109
   505-272-8346

☐ UNM Dental Services @ Camino de Salud Ambulatory Surgical Center
   1801 Camino de Salud, Suite 1100
   Albuquerque, NM 87102
   505-925-7918

☐ UNM Dental Services @ Camino de Salud Ambulatory Surgical Center
   1801 Camino de Salud, Suite 1100
   Albuquerque, NM 87102
   505-925-7918

2. Information to be disclosed:
   ☐ most recent visit/admission  ☐ progress notes  ☐ school records
   ☐ history & physical exam  ☐ laboratory tests  ☐ psychological evaluation
   ☐ initial assessment  ☐ x-ray reports  ☐ physical therapy evaluation
   ☐ consultation reports  ☐ pathology reports  ☐ speech & language evaluation
   ☐ operative report  ☐ ER record/outpatient log  ☐ occupational therapy
   ☐ discharge summary  ☐ Billing
   ☐ Other (please specify): ________________________________

Covering the period(s) of healthcare: from (date)____________ to (date)____________
from (date)____________ to (date)____________

UNMMG C107 5/3/13
3. I further authorize that this disclosure of health information will include information relating to (initial if applicable):
   a. acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, or other sexually transmitted diseases ____ initial
   b. behavioral health services/psychiatric care ____ initial
   c. treatment for alcohol and/or drug abuse ____ initial
   d. genetic test results and related patient information ____ initial

4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _________________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this Authorization and need not sign this Authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed Authorization will be provided to me.

<table>
<thead>
<tr>
<th>Signature, Patient, or legal representative</th>
<th>(Relationship to patient)</th>
<th>(Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Witness</td>
<td>(Date)</td>
<td>(Parent, if CPH/PFC&amp;A patient over 14)</td>
</tr>
</tbody>
</table>

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part 2) and State laws (NMSA 1978 §§ 43-1-19, 32A-6A-24, 24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information, and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.