Medical Interpreting During Interdisciplinary Developmental Assessments of Children

Course Handbook

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Medical Interpreting During Interdisciplinary Developmental Assessments of Children

Learning Objectives:

1. Define pediatric developmental assessment and understand related terminology
2. Understand need for different interpreting techniques for pediatric developmental assessments
3. Learn how to partner with clinicians from different disciplines when interpreting for pediatric developmental assessments

For explanation of terms, refer to Glossary of Terms on pages 25-31 of course handbook.
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1. Define pediatric developmental assessment and understand related terminology
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UW Center on Human Development and Disability (CHDD)

What we do:
- Serve patients and families across the life span
- Provide interdisciplinary assessment, diagnosis, recommendations
- Evaluate children ages birth-18 years in the pediatric clinics
- Train students, professionals, and community members

(See page 8 Child Development Clinic Description in course handbook)
Pediatric Clinics at CHDD

- Child Development Clinic
- Infant Development Follow-Up Clinic
- Fetal Alcohol Spectrum Clinic
- Cardiac Neurodevelopmental Clinic
- Down Syndrome Specialty Clinic
- Congenital Hypothyroid Clinic
- PKU Clinic
- Biochemical Genetics Clinic

www.chdd.washington.edu

CHDD Child Development Clinic

Clinic Assessment Process

- RE Referral
  - COLLECT PATIENT INFORMATION
  - APPOINTMENT SCHEDULING
  - TEAM PREPARATION
  - TEAM EVALUATIONS (with interpreter)

Continued on next slide

Child Development Clinic

Clinic Assessment Process (Cont.)

- POST EVALUATION WORK BY CLINICIAN
  - CASE CONFERENCE
  - PARENT CONFERENCE (with interpreter)
  - REPORT PROCESSING
  - POST ASSESSMENT STEPS
Types of Tests Used in Developmental Assessments

- Interview
- Observation
- Questionnaires
- Standardized tests
- Non-standardized tests

Typical Child Development

Refer to information in Table 1, “Typical Developmental Milestones – Birth through 6 Years” located in course handbook on pages 9-10.

Common Diagnoses Requiring Developmental Assessments

- Autism spectrum disorder (ASD)
- Intellectual disability
- Attention deficit hyperactivity disorder (ADHD)
- Developmental delay
- Language disorder
- Down syndrome

Role of Interpreter: Medical Appointment vs. Developmental Assessment

See Table 3. Comparison of Clinician/Patient Interactions in Medical Encounters in course handbook on page 13

- Useful in other settings beside CHDD
  -- Schools
  -- Seattle Children's Hospital
  -- UW Autism Center
  -- Birth-to-3 Centers

Guidelines for Working with Pediatric Patients

→Follow the clinician’s lead←

Guidelines for Working with Pediatric Patients

- **Infants under 6 months**
  - Interpret for clinician and family; not necessary for baby

- **Infants 6-12 months**
  - Interpret directions and all verbal interactions by clinician with baby
  - Identify any sounds/words spoken by baby
  - Interpret for family

(See course handbook pages 14-15)
Guidelines for Working with Pediatric Patients

Toddlers and preschoolers

- Get down on level of child
- Be flexible and move with child; dress appropriately for movement
- Ignore the child’s dropping or throwing behaviors
- Interpret child’s sounds, words, and anything spoken between parent and child

Guidelines for Working with Pediatric Patients

Communication challenges

- Interpret exactly what child says
- Give feedback if pronunciation or grammatical errors are made by child in their first language

Sensory issues

- Give child personal space; they may be sensitive to touch, sound, lights
- Child may get upset easily due to high level of sensitivity

Guideline for Working With Pediatric Patients

Attention difficulties

- Different objects/toys may be used to keep child on task
- Limited stimuli in room is to reduce distractions

High levels of activity

- Child may be physically active for various reasons
- Special tools may be used with child (e.g. seat cushion, hands fidgets, vest)
- Frequent movement breaks will be given to child

Atypical Behaviors

- May include: hand flapping, spinning, squealing, running in circles; ignore these behaviors
**Interpreter Attributes**

- Has self-awareness of own attitudes toward individuals with disabilities
- Is calm and has patience
- Shows kindness and friendliness toward parents and children of all ages
- Has flexibility (to accommodate to changes in schedule and child’s needs; to physically move around with child)

**Interpreter Skill Base**

- Has knowledge of medical terminology related to physical, mental, and social development
- Knows how to access resources about typical child development
- Is familiar with where to find information about common neurodevelopmental disorders

**Interpreter Skill Base (Cont.)**

- Has ability to accept guidance from multiple clinicians during evaluation process
- Shows alertness to possible cultural misunderstandings and the need to cue clinician accordingly
Keys to Effective Partnership Between Interpreter and Clinicians in Developmental Assessments

- Participates in brief information sharing prior to each assessment
- Follows clinician’s lead
- Asks clarifying questions of clinician or interpreter
- Understands role during appointments

(Refer to discipline descriptions in course handbook on pages 14-24)

Resources

- UW Center on Human Development and Disability
  http://depts.washington.edu/chdd/gist/about_chdd.html
- Free library of photos and videos of developmental milestones from national Centers for Disease Control and Prevention.
- Yardsticks: Children in the Classroom Ages 4-14. 3rd Edition. by Chip Wood

Acknowledgements

This training was developed by the Clinical Services Committee at the UW Center on Human Development and Disability (CHDD).

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Child Development Clinic Description

The Child Development Clinic at CHDD provides interdisciplinary assessment, diagnosis, and recommendations for children from birth through adolescence who are at risk for or have developmental disabilities. Autism, developmental delay, learning disability, behavioral disorder, language disorder, and intellectual disability are some of the more common diagnoses made at CHDD.

Referrals come from families, doctors, therapists, schools and other sources. A child may have from 2 to 5 separate appointments that last from 30 minutes to 2 1/2 hours each. It will take 2 to 3 days to finish all the testing.

The assessment can include interview with parents, observation of child, standardized testing, informal interaction with child, parent questionnaires or a combination of these. Tools chosen are based on child’s age, area of concern, language/cognitive levels, and time available.

CHDD is a training facility. There will often be one or more professionals in training who will be present observing the assessment or completing the assessment. There may be multiple observers in the observation room including trainees, family member, others.

After the child has had all the evaluations, the parents return without the child to meet with the team that conducted the assessment. At that meeting, the team gives the results of their testing, primary diagnoses/impressions, and recommendations. At CHDD, clinicians don’t provide services beyond testing. Recommended services are provided in the child’s community and at school. The family is given a brief written summary of the points discussed at the meeting. Longer, more complete reports are provided to the family by each clinician one month following the parent conference.
<table>
<thead>
<tr>
<th>AGE MOS.</th>
<th>GROSS MOTOR</th>
<th>FINE MOTOR</th>
<th>SELF-HELP</th>
<th>PROBLEM SOLVING</th>
<th>SOCIAL EMOTIONAL</th>
<th>RECEPTIVE LANGUAGE</th>
<th>EXPRESSIVE LANGUAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chin up in prone</td>
<td>Hands listed near face</td>
<td></td>
<td>Fixes on ring</td>
<td>Follows face</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Chest up in prone, head bolts when held in sitting</td>
<td>Hands unfisted 50%</td>
<td></td>
<td>Visual threat present</td>
<td>Follows ring</td>
<td>Recognizes mother</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Props on forearms in prone, suspended in prone</td>
<td>Hands unfisted 50%</td>
<td></td>
<td>Reaches for face</td>
<td>Follows ring in circle (in supine)</td>
<td>Regards cube</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sit w/ trunk support</td>
<td>Clutches at clothes</td>
<td></td>
<td>Mouts objects</td>
<td>Aware of strange situation</td>
<td></td>
<td>Smiles spontaneously at pleasurable sight/sound</td>
</tr>
<tr>
<td>5</td>
<td>Sits w/ pelvic support</td>
<td>Palmar grasp/cube</td>
<td></td>
<td>Feeds self crackers</td>
<td>Places hands on bottle</td>
<td></td>
<td>Stranger anxiety (familiar vs. unfamiliar people)</td>
</tr>
<tr>
<td>6</td>
<td>Sits momentarily propped on hands</td>
<td>Transfers hand-hand</td>
<td></td>
<td>Touches reflection and vocalizes</td>
<td>Removes cloth on face</td>
<td></td>
<td>Stops momentarily to ‘no’</td>
</tr>
<tr>
<td>7</td>
<td>Bounces when held, sits w/o support – steady</td>
<td>Radial-palmar grasp</td>
<td></td>
<td>Feeds</td>
<td>Places hands on bottle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Gets into sitting, commando crawls</td>
<td>Bangs spoon w/ demo</td>
<td></td>
<td>Seeks object after it falls silently to the floor</td>
<td></td>
<td></td>
<td>Dada’ inappropriate Echolalia (8-30 mos)</td>
</tr>
<tr>
<td>9</td>
<td>Gets to 4-pt</td>
<td>Scissor grasp of pellet</td>
<td></td>
<td>Engages in gaze monitoring: adult looks away and child follows adult glance with own eyes</td>
<td></td>
<td></td>
<td>Mama’ inappropriate</td>
</tr>
<tr>
<td>10</td>
<td>Creeps well</td>
<td>Chamy release of cube</td>
<td></td>
<td>Uncovers toy under cloth</td>
<td>Places cloth on face</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Walks – 1 hand held</td>
<td>Throws objects</td>
<td></td>
<td>Finds toy under cup</td>
<td>Looks at pictures in book</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Stands well, posterior protection</td>
<td>Marks after demo</td>
<td></td>
<td>Finger feeds part of meal</td>
<td>Takes hat off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Throws ball – sitting</td>
<td>Attempts to release</td>
<td></td>
<td>Drinks from cup w/ spilling</td>
<td>Dangles ring by string</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Stands w/o pulling up</td>
<td>Imitates back-forth scribble</td>
<td></td>
<td>Removes socks/shoes</td>
<td>Chews well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Hops to pick up toy</td>
<td>3-cube tower</td>
<td></td>
<td>Uses spoon – some spill</td>
<td>Turns pages in book</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Stands on 1 foot w/ slight support</td>
<td>All round pegs in with</td>
<td></td>
<td>Kisses by touching lips to skin</td>
<td>Periodically visually relocates caregiver</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Developmental Milestones – Birth through 6 years

Adapted by Beth Ellen Davis MD, MPH – Center on Human Development and Disability, University of Washington
<table>
<thead>
<tr>
<th>AGE MOS</th>
<th>GROSS MOTOR</th>
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</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Creeps down stairs Runs well Seats self in small chair Throws ball – standing</td>
<td>4-cube tower Crudely imitates vertical stroke</td>
<td>Removes garment Gets onto adult chair without adult Moves about house without adult</td>
<td>Matches pairs of objects Circle reversed after searching</td>
<td>Passes CHAT Engages in pretend play (e.g. tea party, birthday party – with other people) Begins to show shame (when does wrong) &amp; possessiveness</td>
<td>Points to 2 of 3 objects Body parts: 3 Points to self Understands “mine”</td>
<td>10-25 words Giant words (all gone, stop that) Imitates environmental sounds Names one picture on demand</td>
</tr>
<tr>
<td>20</td>
<td>Squats in play Carries large object Up stairs holding onto one hand</td>
<td>Completes round peg board w/o urging 5-6 cube tower Completes square peg board Places only edibles in mouth Feeds self w/ spoon entire meal</td>
<td>Begins to have thoughts about feelings Engages in tea party with stuffed animals Kisses with pucker</td>
<td>Begins to understand her/him/me</td>
<td>Points to pictures: 3 Points to understand her/him/me</td>
<td>Holophrases (“Mommy?” and points keys: “These are Mommy’s keys.”) 2-word combinations Answers requests w/ “no”</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Up stairs with rail, marking time Kicks ball w/ demo Walks w/ one foot on walking board</td>
<td>Closes box with lid Imitates vertical line Imitates circular scribble Uses spoon well Drinks from cup well Unzips zippers Puts shoes on partway</td>
<td>Adapts to FB reversal within 4 trials Completes form board</td>
<td></td>
<td>Pictures: 4-5 Body parts: 5-6 Clothing: 4 pieces</td>
<td>25-50 words Asks for more Adds 1-2 words/week</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Down stairs with rail, marking time Jumps in place Kicks ball w/ demo Throws overhand</td>
<td>Train of cubes w/o stack Up stairs w/o assisting time Imitates horizontal line Opens door using knob Sticks through a straw Takes off clothes w/o buttons Pulls off pants</td>
<td>Sorts objects Matches objects to pictures Shows use of familiar obj</td>
<td>Parallel play Begins to mask emotions for social etiquette</td>
<td>Follows 2-step command Understands me/you Points to 5-10 pictures</td>
<td>2-word sentence (N + V) Telegraphic speech 50+ words 50% intelligibility Refers to self by name Names 3 pictures</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Jumps from bottom step – 1 foot leading Walks on toes after demo Walks backward 10 ft</td>
<td>Strings beads awkwardly Unstrings jar lid</td>
<td>Holds self-verbalizes toilet needs Pulls pants up with assistance</td>
<td>Matches shapes Matches colors</td>
<td>Understands “just one”</td>
<td>Repeats 2 digits Begins to use pronouns (I, me, you) Names 10-15 pictures</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Up stairs with rail, alternating feet Jumps in place Stands w/ both feet on balance beam Walks w/ one foot on balance beam</td>
<td>8-cube tower Train of cubes with slack</td>
<td>Washes hands Puts things away Brushes teeth w/ assistance</td>
<td>Reverses form board spontaneously Points to small details in pictures Pretend play – advanced</td>
<td>Follows 2 prepositions: “put block in… on box” Understands actions words: “playing… washing… blowing”</td>
<td>Echolalia &amp; jargon gone Names objects by use Refers to self w/ correct pronoun</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Balances 1 ft – 3 sec Ustairs, alternating feet, without rail</td>
<td>9-10-cube tower Toilet trained Sorts pegs in pegboard Imitates cross</td>
<td>Points to self in photos Points to body parts acc’d to function (“what do you hear with?”)</td>
<td>Starts to share with/without prompt Fears imaginary things Imaginative play Uses words to describe what someone else is thinking (Mom thought I was asleep)</td>
<td>Begins to use past tense</td>
<td>Gives first &amp; last name Counts to 3 Begins to use past tense</td>
<td></td>
</tr>
<tr>
<td>3 yr</td>
<td>Balances 1 ft – 3 sec Ustairs, alternating feet, without rail</td>
<td>Copies circle Cuts w/ scissors: side-to-side (awkwardly) Imitates bridge Strings small beads well</td>
<td>Independent eating Pours liquid from one container to another Puts on shoes w/ adult assistance Spreads w/ knife Unbuttons</td>
<td>Adds 2 parts to DAP Understands long/short, big/small, more/less Knows own gender Knows own age</td>
<td>Points to parts of pictures (nose of cow, door of car) Understands long/short Names body parts w/ function Understands negatives Groups objects (foods, toys)</td>
<td>200+ words 3-word sentences Uses pronouns correctly 75% intelligibility Uses plurals Names body parts by use</td>
<td></td>
</tr>
<tr>
<td>4 yr</td>
<td>Balances 1 ft – 3 sec Ustairs, alternating feet, without rail</td>
<td>Copies square Cuts 5-inch circle Uses tongs to transfer</td>
<td>Goes to toilet alone Wipes after BM Washes face/hands Brushes teeth alone Buttons Uses fork well</td>
<td>DAP = 4-6 parts Number concepts to 2 Simple analogies: - dad/dad = mother/mother? - ice/cold : fire/??? - ceiling/roof : floor/??? Points to 4 colors</td>
<td>Passes Sally &amp; Anne test Deception – interested in “tricking” others &amp; concerned about being tricked by others Has a preferred friend Labels happiness, sadness, fear, &amp; anger in self Group play</td>
<td>Follows 3-step commands Points to 4 colors Understands action words: II – (swims in water, cuts with, is read, sit at, tells time…) Understands adjectives: bushy, long, thin, pointed</td>
<td>Digits: 3 forward 300-1000 words Tells stories Counts to 4 Names 4 colors 100% intelligibility Uses “feeling” words</td>
</tr>
<tr>
<td>5 yr</td>
<td>Balances 1 ft – 3 sec Ustairs, alternating feet, without rail</td>
<td>Copies triangle Builds stairs from model Uses paper clip on paper Can use clothespins to transfer small objects</td>
<td>Spreads with knife Independent dressing Bathes independently</td>
<td>DAP = 8-10 parts Number concepts to 3 Identifies coins Standardized IQ test needed</td>
<td>Has a group of friends Apologizes for mistakes Responds verbally to good fortune of others Understands seasons &amp; group play</td>
<td>R &amp; L on self (5-7 yrs) Points to different one in a series Understands “er” endings (batter, skater)</td>
<td>Digits: 4 forward Counts to 10 Colors: 4-6 Defines simple words 2000 words Knows telephone number Responds to why questions</td>
</tr>
<tr>
<td>6 yr</td>
<td>Tandem walks</td>
<td></td>
<td>Ties shoes Combs hair Looks both ways at street</td>
<td>DAP = 12-14 parts Number concepts to 10 Simple addition Understands seasons &amp; group play</td>
<td>Has best friend of same sex Plays board games</td>
<td>Reads at first-grade level Use PPVT</td>
<td>Days of the week 10,000 words when enters first grade</td>
</tr>
</tbody>
</table>

Table 1. Developmental Milestones – Birth through 6 years

Adapted by Beth Ellen Davis MD, MPH – Center on Human Development and Disability, University of Washington
Table 2. Common Neurodevelopmental Conditions in Children

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age of Diagnosis</th>
<th>Description/Features</th>
<th>Typical questions asked during parent conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism spectrum disorder (ASD)</td>
<td>2 years and older</td>
<td>Decreased eye contact and response to name, little interest in social engagement, repetitive behaviors</td>
<td>What kind of autism does my child have? Is it mild or severe? How can I help my child? Was it caused by immunizations?</td>
</tr>
<tr>
<td>Intellectual Disability (ID)</td>
<td>6 years and older</td>
<td>Delays in cognitive (thinking skills) and adaptive skills (daily functioning)</td>
<td>Will my child grow out of it? Will my child learn? Will they live on their own? Will my child go to college?</td>
</tr>
<tr>
<td>Developmental Delay</td>
<td>Toddler-age 6</td>
<td>Used to describe delays in multiple areas-cognitive, language, motor</td>
<td>Same as ID</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>5-7 years old, can be later</td>
<td>Difficulties with inattention, impulsivity, and hyperactivity in two settings; e.g., home, school; Types: Inattentive, Hyperactive/Impulsive, or Combined</td>
<td>Will my child grow out of it? Is medication necessary? Why won’t my child just behave?</td>
</tr>
<tr>
<td>Language Disorder</td>
<td>3-6 years old</td>
<td>Does not understand and/or use words as well as peers; has trouble communicating</td>
<td>Will my child grow out of it? Is it because my child does not want to talk? How can I help my child? Is it because we speak two languages? Should we just speak English?</td>
</tr>
<tr>
<td>Speech Disorders</td>
<td>Toddler-early childhood</td>
<td>Difficulties making the sounds that comprise words; their speech is hard to understand</td>
<td>Is it because we speak two languages? Will my child grow out of it? What will help my child talk better? Should we just speak English?</td>
</tr>
</tbody>
</table>
Table 2. Common Neurodevelopmental Conditions in Children (cont.)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age of Diagnosis</th>
<th>Description/Features</th>
<th>Typical questions asked during parent conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Down syndrome</td>
<td>Birth to early infancy</td>
<td>Unusual facial features, low muscle tone, increased risk of cardiac abnormalities; cognitive delays.</td>
<td>Will my child be able to learn? What caused this?</td>
</tr>
<tr>
<td>Cerebral Palsy (CP)</td>
<td>One year to early childhood</td>
<td>A range of motor difficulties which may include tight muscles and joints and difficulty with walking, fine motor skills, and speech.</td>
<td>What caused this? Will my child ever walk? Can my child think and learn?</td>
</tr>
<tr>
<td>Prematurity</td>
<td>24 to 37 weeks gestation</td>
<td>Early respiratory and feeding problems can lead to long NICU stay. Increased risk of developmental delays.</td>
<td>Worries about baby’s health including whether they can go out in public settings. What problems is my child likely to have as he grows up?</td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome (FAS)</td>
<td>Infancy to early childhood</td>
<td>Growth difficulties, damage to the brain, thin upper lip, smooth philtrum, and small eyes in the context of alcohol exposure during pregnancy.</td>
<td>Are all of my child’s problems caused by alcohol exposure? How can I help my child grow and learn? What do I tell my child about their problems?</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>8-10 years</td>
<td>Difficulties learning reading, math or writing that do not match cognitive ability.</td>
<td>How can I help my child? Why can’t my child learn? Will my child go to college? Is it because my child does not try hard enough? Are they smart?</td>
</tr>
</tbody>
</table>

Kathleen Lehman, PhD & Anne Leavitt, MD – Center on Human Development and Disability, University of Washington, 12/16
Table 3. Comparison of Clinician/Patient Interactions in Medical Encounters

<table>
<thead>
<tr>
<th>ADULT MEDICAL ENCOUNTER</th>
<th>CHILD MEDICAL ENCOUNTER</th>
<th>DEVELOPMENTAL EVALUATION OF CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient presents complaint/concern about own health</td>
<td>Parent/caregiver presents concern about <em>their</em> child’s health/development</td>
<td>Parent/caregiver presents concern about <em>their child’s</em> health/development</td>
</tr>
<tr>
<td>Patient communicates directly with clinician</td>
<td>Much of communication is via parent but child may also respond</td>
<td>In testing situation, much of clinician’s communication is directly with child though some parent interview and/or observation will occur</td>
</tr>
<tr>
<td>Patient comes by self or may bring family member</td>
<td>Child is brought by parent who typically remains in room</td>
<td>Depending on age of child, parent may be in observation room</td>
</tr>
<tr>
<td>Patient gives consent for care</td>
<td>Parent gives consent for care</td>
<td>Parent gives consent for care</td>
</tr>
<tr>
<td></td>
<td>Children 13 years and older must give own consent for care</td>
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Kay Kopp, OTR/L, Center on Human Development and Disability, University of Washington 11/16
Guidelines for Working with Pediatric Patients

General Guidelines:

Follow the clinician’s lead. This includes how quiet or animated your voice and mannerisms should be. Some of the children seen in this clinic are more sensitive or reactive to sounds, stimulation, and new environments.

- For all children over 6 months of age, interpret ALL spoken communication (directions and comments) that the clinician says.
- Interpret exactly what the clinician/child/or parent says. This includes comments between parent/child and parent/parent. Additional comments might interfere with test results.
- Allow the clinician to manage the child’s behavior.
- Refrain from praising child; leave this to the clinician.
- Let the clinician know if there are any words that cannot be interpreted (i.e.: there is no word for children in that language).
- Standardized testing requires the clinician to use the exact same content and procedures (i.e., directions, wording of items, clarifying questions, and time limits) for all children. The reason is to reduce bias and influences by the clinician on the child’s performance. When an interpreter is assisting the clinician, the interpreter needs to use the clinician’s exact words (or let the clinician know when this is not possible due to language differences) and the interpreter cannot provide additional explanations or gestures or hints that may influence the child’s performance. The goal is to get a measure of the child’s functioning at that time so that services can be obtained if needed.

Specific Guidelines:

Infants under 6 months

- Interpretation is provided for the clinician and family as needed but would not be necessary for the baby

Infants 6-12 month olds

- Interpret directions and all verbal interactions by the clinician for the baby and identify any sound or words spoken by the baby.
- Interpret for the family.
Toddlers and Preschoolers

- Important to get down on the level of the child.
- Testing will occur at the table, on the floor and in the hallway. Be prepared to be flexible and move with the child. Dress appropriately for movement.
- Since toddlers tend to drop things off the table and toss things, just ignore this.
- Interpret the child’s sounds, words, and anything spoken between the parent and child.

Communication challenges (i.e. non-verbal, limited language use, difficult to understand, low understanding of language)

Interpret exactly what the child says. Please provide feedback to clinician if you note pronunciation and grammatical errors in a language other than English. This is helpful information for test results.

Sensory issues

- Take the lead of the clinician.
- Some children are sensitive to sounds, lights, and touch (pats on the back may be upsetting; give them personal space).
- These children may get upset easily due to their high level of sensitivity.

Attention difficulties

- The clinician may use a number of different objects or toys to help the child remain on task.
- The clinician may limit the amount of stimuli in the room to reduced distractions.

High levels of activity

- Children may be very physically active for various reasons during the visit.
- Clinicians may use special tools to address the child’s need for movement (e.g. seat cushion, lap pad, weighted vest).
- The child will be provided frequent movement breaks which may include opportunities to run in the hallway.

Atypical behaviors

- These are behaviors you may see: hand flapping, spinning, squealing, running in circles, repetitive jumping.
- Ignore these behaviors.
- Follow the clinician’s lead.
Discipline: Audiology

Description of what occurs during the Audiology evaluation:

The child’s hearing levels will be measured with age-appropriate evaluations that involve measuring the child’s behavioral responses to sound or physiological responses to sound. The sounds will be presented to the child via a speaker or earphones. Young children will be taught to play a game in response to sound.

Testing is done in a sound-proof room and, typically, the interpreter is not in the test room while measures are completed, but will be involved before and after.

For children with permanent hearing loss who wear hearing aids, additional testing/measures will be done to adjust the aids for the child. Impressions of the ear and fitting devices onto the ear may be completed during the visit.

Expectations for the interpreter during this evaluation:

The interpreter will translate all conversations directed between the audiologist and the family. If the child is involved in conversations, the interpreter will translate the child’s conversation, as well.
Description of what occurs during the Speech Language Pathology evaluation:

- **Caregiver interview**: Brief interview with family about their concerns.
- **Play observation**: Play with child (perhaps on floor) to observe social interaction, language, play.
- **Testing**: Formal testing at table to look at communication skills. Involves listening, pointing to pictures, and giving verbal responses. Communication skills include:
  - articulation (i.e., pronunciation)
  - expressive language (i.e., grammar and vocabulary the child uses to communicate)
  - receptive language (i.e., the words and sentences a child can understand)
  - Discourse abilities – stories, explanations, conversation
- **Caregiver questionnaire**: Therapist might ask the child’s caregiver to fill out a questionnaire about the words a child says and understands, or about the ways in which a child uses language.
- **Appointment lasts 90 minutes**.

Expectations for the interpreter during this evaluation:

- Interpret word for word during interview.
- During testing:
  - **Tell clinician everything the child says**, even if just a single word. Some aspects of the child’s communication skills that are of particular interest to the clinician:
    - How easily can the child be understood? The clinician is interested in whether the child’s pronunciation is similar to other children the same age.
    - Are the child’s sentences grammatical? Or are there errors?
    - The clinician is interested in knowing whether the child uses:
      - “jargon”: speech with no recognizable words in any language
      - “scripting”: quoting verbatim from TV shows or movies
      - “echolalia”: repeating what other people say
  - **Administration of the test**: expect the clinician to provide you with precise instructions for each test/task. Sometimes you may be asked to wait while the test is administered in English, then to provide translation after English administration is complete. When translating: if the clinician asks a question, translate as a question; if a single word, translate as a single word; if a statement, translate as a statement. Also be sure you are clear about what the target is. For example, a word like “letter” might mean a symbol for writing (i.e., the ABC’s) or a “written correspondence.” – Be sure to clarify when you are not sure.
- Help translate written questionnaires for parents to complete. If any of the questions are unclear, please check in with the clinician to clarify.
- **For Spanish interpreters only**: We have Spanish or bilingual English/Spanish tests. If the clinician does not speak Spanish the interpreter may be asked to provide assistance in administering test items in Spanish. When doing this, it is important to read exactly what is written and not change or add to wording. It is also important to speak directly to the child, and to interpret exactly what the child’s response is without adding words or correcting grammar in the child’s response.
Discipline: Psychology

Description of what occurs during the Psychology evaluation:

- Testing at table to look at cognitive (thinking), academic (reading, math, & writing), memory, and/or attention skills. Usually involves blocks, puzzle pieces, copying designs using pencil and paper, flip books with pictures and patterns, and questions.
- Parent may be in the room or in the observation room when children are over 4 years old.
- Testing very young children (1-2 years old) will involve the child sitting on caregiver’s lap facing the table. Toys and objects are provided to look at child’s thinking skills, language skills, and motor skills. Some activities are completed on the floor and in the hallway.
- Play with the child to observe the child’s social interaction skills, communication, and play activities.
- Caregiver may be asked to complete questionnaires about behavior, attention, and daily skills at home and in the community.
- Psychologist may ask the caregiver questions about the child’s behavior, communication, and social skills. Additional questions may be asked about the child’s educational program.
- Appointment typically lasts 2½ -3 hours in child development clinic and 1-2 hours in infant development and cardiac neurodevelopment clinics.

Expectations for the interpreter during this evaluation:

- Testing is standardized so that the directions have to be given to each child in the same way and assistance/clues cannot be given. This is to determine where the child’s level of functioning is now so the child can receive help that is needed in terms of services.
- Let the psychologist know if words being said cannot be translated the same way. For example, in some languages there is no word for “children.”
- Interpret everything the psychologist says to the parent and child during the testing and interview.
- With very young children (1-2 years old), it is important to interpret all directions and comments made by the psychologist so that the psychologist can see how the child responds.
- Tell the psychologist everything that the child says, even if it is just a single word.
- Help the parent complete questionnaires by translating the forms.
- Allow the psychologist to manage child’s behaviors.
Description of what occurs during this evaluation:

Children are weighed and have height and head measurements taken. Children over 3 years old stand on the scale to be weighed, stand up against the wall to get height measured, and a paper measuring tape is placed around their head to get a head measurement. Babies/children less than 3 years sit on the table scale to be weighed, lay down along the measuring board to get length and have a paper measuring tape place around their head while their parent holds them. Typically lasts 10 minutes.

Expectations for the interpreter during this evaluation:

During this short but important appointment, we need the interpreter to give the family our instructions for what clothing needs to be removed*, how to help position their child, and to relay the measurements to the family.

*Any child under the age of 3 needs to be stripped down to a dry diaper. (Parents may be asked to change a diaper first if wet). Over age 3 years of age only shoes need to be removed.
Description of what occurs during the Developmental Pediatrics evaluation:

During this evaluation, a thorough family history is taken through interview with the parents/guardians. The parents are asked regarding concerns about their child including development, health, growth, and behavior. Frequently a medical fellow or resident may participate in this appointment and may play a game with the child during the parent interview when sensitive questions may be discussed. A physical exam is conducted which includes undressing the child, listening to the heart and lungs, and tapping on knees and elbows with a reflex hammer. The child may be asked to do some basic physical actions such as walking, running, or climbing stairs. There are no shots or lab tests done during this appointment which takes about 60 minutes.

Expectations for the interpreter during this evaluation:

Interpret all comments made by the family and patient.
Description of what occurs during the Nurse Practitioner evaluation:

During this evaluation, several photographs will be taken of the child’s face. A sticker will be temporarily placed on the child’s forehead to align the camera properly. The child will be asked to follow specific directions for the photograph such as to sit up straight, have his or her lips closed (no smile), and look upwards.

Following the photo, an interview of the parent/guardian will take place asking specific questions about the child’s medical history.

There are no shots or lab tests done during this appointment. This appointment takes about 30 minutes and may be combined with other appointments.

Expectations for the interpreter during this evaluation:

Interpret all instructions to patient for photograph.

Interpret all comments made by the family and patient.
Discipline: Occupational Therapy/Physical Therapy

Description of what occurs during the Occupational or Physical Therapy evaluation:

- Brief interview with family about their related concerns, child’s interests, child’s school and therapies.
- Testing at table to look at fine motor ability. Usually involves some type of writing, cutting, manipulating small objects.
- Testing to look at gross motor (large physical) skills that may involve some type of balance, ball handling, jumping, running, and various other physical activities. Sometimes tasks are completed in the hallway.
- Some physical handling of child to assess muscles and joints, posture, mobility, etc. takes place on therapy mat. Child may have to partially undress.
- Play with child to observe social interaction skills, language, play, direction following, etc. Often sensory materials are used such as different types of swings, big therapy balls, toys that flash or make noises.
- Therapist might ask parent to fill out a questionnaire about sensory information.
- Therapist might ask the parent about the child’s self-care skills.
- Appointment typically lasts 90 minutes.

Expectations for the interpreter during this evaluation:

- Interpret word for word what the clinician says to parents and child during interview and formal testing.
- Tell clinician everything the child says, even if just a single word.
- Help translate written questionnaires for parents to complete. You can record parent’s response or show them where and how to mark their response.
- Do not need to physically copy clinician’s demonstrations but do interpret verbal instructions as clinician demonstrates.
Discipline: Nutrition

Description of what occurs during the Nutrition evaluation:

The registered dietitian nutritionist (RDN) will ask:

- about feeding or growth concerns that the parent/guardian may have about their child.
- if the child can tell the parent/guardian that he/she is hungry or full.
- about the foods that the child may be allergic to or may avoid for some other reason.
- parent/guardian questions about what foods the child eats for meals and snacks. The RDN may use food models, measuring cups/spoons and glasses to determine the amounts and types of foods and beverages that the child eats/drinks and how often the child eats that specific food or beverage.
- about the child’s physical activity and quiet activities
- about access to food and meals away from home.

The RDN will describe the child’s growth pattern using a growth chart

The RDN may ask to see a picture of the child being evaluated if the child is not present.

The interview typically lasts about 1 hour.

Expectations for the interpreter during this evaluation:

- Interpret word for word what the RDN says to the parent and child during the interview.
- Tell the RDN everything the parent and the child (if the interviewer asks the child a question) says, even if it is just a single word.
- Help to translate when written information is requested.
- Please do not discuss other items with parent during the interview or share information related to food and beverages other than those comments provided by the RDN.
Discipline: Social Work

Description of what occurs during the Social Work evaluation:

- The role of the social worker in this team evaluation is to get the “big picture.” We gather information about the child’s environment and assess how we can best meet the needs of the child in the context of their unique environment.
- In-depth interview with parent(s) or caregiver(s) without child present.
- Topics covered in the interview might include:
  - Caregiver’s concerns about child and the evaluation process
  - Caregiver’s experience and impressions of evaluation at CHDD
  - Family constellation/environment (who lives in home, extended family, etc.)
  - Caregiver’s education and employment, source of income, income level
  - Caregiver’s impression of child’s strengths, skills, and personality
  - Caregiver’s mental health
  - Child’s school placement
  - Daily routines
  - Family leisure, social activities
  - Recent stressful events and trauma
  - History of drug and alcohol abuse
  - History of physical/sexual/spouse abuse or neglect
  - Family support systems
  - Religious and cultural affiliations
  - History of social services and advocacy
- Appointment typically lasts 90 minutes.

Expectations for the interpreter during this evaluation:

- Interpret word for word what the clinician says to caregiver during interview.
- Tell clinician everything the caregiver says, even if just a single word.
- Tell clinician everything, even if the material is sensitive, difficult, or embarrassing.
Glossary of Terms
Related to Neurodevelopmental Disabilities

A

**AAC - Augmentative and Alternative Communication**: Any method of communicating without speech, such as by signs, gestures, picture boards, or electronic or non-electronic devices. These methods can help individuals who are unable to use speech or who need to supplement their speech to communicate effectively.

**ABA—Applied Behavior Analysis**: ABA is the name of a professional field that uses principles of learning to increase performance of socially desirable behaviors. It always relies upon the collection of objective data to measure performance and the effectiveness of an intervention. The term “ABA” is sometimes used to refer to a one-on-one therapy that is named discrete trial training; however, it can also be applied using an incidental teaching approach. ABA practitioners carefully observe and measure behaviors and the context in which they occur in order to individualize teaching plans to improve narrowly defined behaviors. ABA is commonly used as one component in interventions for Autism Spectrum Disorders.

**Adaptive behavior**: Includes communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. These are skills that help the person be successful in their environment and are learned skills rather than innate abilities.

**ADHD—Attention Deficit Hyperactivity Disorder**: A disorder that shows up in the areas of inattention, hyperactivity, and impulsiveness. It is evidenced by frequent shifting from one activity or focus to another, having difficulty organizing and completing tasks correctly, impulsive response, or failure to follow rules. It may occur with or without hyperactivity which includes behaviors such as excessive running, talking, fidgeting, and/or restlessness.

**Apraxia**: see “Dyspraxia”.

**Advanced Registered Nurse Practitioner (ARNP)**: Is a registered nurse who has obtained a master’s degree or higher and has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, including duties and responsibilities formerly carried out only by a physician.
**ASD - Autism Spectrum Disorder:** Is a neurodevelopmental disorder. ASD symptoms are typically evident before a child is 3 years of age. The symptoms range from mild to severe – and individuals often have varied skills levels in different domains of functioning. Autism affects the person’s overall development in 2 primary areas:

1) *social communication*, or the way a person uses gestures, body language, and language to communicate and interact socially and relate with others

2) the presence of *restricted, repetitive patterns of behavior, interests, or activities* (e.g., repetitive motor movements, echolalia/repeating speech, idiosyncratic phrases, extreme distress at small changes/difficulty with transitions, strong attachment to unusual objects/topics, adverse or intense responses to sensory input).

**Audiologist:** A specialist who evaluates for hearing loss as a potential cause or contributor to developmental delay, and designs/supports interventions to minimize the impact of hearing loss when it is found.

**C**

**CH - Congenital Hypothyroidism:** A condition in which there is inadequate thyroid hormone production that affects infants from birth. CH occurs when the thyroid gland fails to develop or function properly. Identification is through national mandated newborn screening. Treatment consists of a daily dose of thyroid hormone by mouth. If untreated, congenital hypothyroidism can lead to intellectual disability and slow growth.

**Cognitive development:** How children learn to think, interpret information, make decisions, and solve problems. Areas of cognitive development include verbal reasoning (using language), non-verbal reasoning (using visual/spatial information), as well as executive control/functioning.

**Communication:** The developmental area that involves skills which enable people to understand (receptive communication) and share (expressive communication) thoughts and feelings. Waving goodbye, smiling, nodding, making eye-contact, using spoken language, following directions, and reading and writing are examples of communication.

**Communication disorder:** Difficulty with understanding and/or expressing messages. Communication disorders include problems with hearing, with making speech sounds (articulation), with having a clear voice (voice disorders), stuttering (fluency disorders), difficulty learning, knowing and using grammar (language disorders), difficulty using language to get things done (social communication or pragmatic language disorders), and using language to learn (language-based learning disabilities such as dyslexia).

**CP - Cerebral Palsy:** A condition caused by injury to the brain or abnormal development of a child’s brain while it is still developing – before birth, during birth, or immediately after birth. CP affects body movement, muscle control and coordination, muscle tone, reflexes, posture, and balance. The degree of impairment can be mild, moderate or severe and can impact all areas of development.
Developmental assessment: A structured evaluation of a child’s development in one or more areas including cognitive, language, motor, social/emotional, and adaptive. Professionals that conduct developmental assessments include: developmental behavioral pediatricians, psychologists, speech language pathologists, occupational therapists, physical therapists, educators, and audiologists. Types of tests that are used during developmental assessments include interview, observation, questionnaires, standardized tests, and non-standardized tests.

Developmental delay: The term used to describe the condition of an infant or young child who is not achieving new skills in the typical time frame and/or is exhibiting behaviors that are not appropriate for his or her age. Some children who are developmentally delayed eventually have a specific diagnosis of a particular developmental disability. Other children with delays catch up with their typically developing peers.

DD - Developmental disability: A severe chronic disability that is attributed to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments, is manifested before the individual attains the age of 22, is likely to continue indefinitely, results in the inability to live independently without external support or continuing and regular assistance, reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are planned and coordinated for that individual.

Developmental Pediatrician: Also known as a developmental-behavioral pediatrician, these professionals have training and experience to assess and treat a wide range of medical and psychosocial aspects of a child’s developmental and behavioral difficulties. Their expertise may make them a good choice for children with complicated medical or developmental problems.

Down syndrome (also known as Trisomy 21): The most common and readily identifiable chromosomal condition associated with intellectual disability. Children with Down syndrome typically have developmental delays but this can range from mild to severe. Common physical signs of Down syndrome include: decreased muscle tone; short neck; flattened facial profile and nose; small head, ears, and mouth; upward slanting eyes; white spots on the colored part of the eye (called Brushfield spots); wide, short hands with short fingers; a single, deep, crease across the palm of the hand; a deep groove between the first and second toes.

Dysarthria: A term used to describe the impact on speech production of muscle weakness and/or reduced muscle control due to neural damage.

Dyslexia: Impaired reading ability. Dyslexia is a specific neurodevelopmental learning disability. It is characterized by difficulties with accurate and/or fluent word recognition and by challenges in spelling and decoding abilities. These challenges typically result from a deficit in the phonological component of language, and are often unanticipated in relation to other cognitive abilities, and in the provision of effective classroom instruction.
**Dyspraxia**: A condition characterized by a difficulty with planning and performing coordinated movements although there is no apparent damage to muscles. Dyspraxia can impact any motor system, and will be described based on the motor system affected (e.g., upper limb dyspraxia, speech/verbal dyspraxia). The term “apraxia” is often used as a synonym for dyspraxia.

**Executive control/ Executive functioning**: A group of skills that helps people plan, organize, control behavior, focus on multiple streams of information at the same time, self-monitor, and revise action plans as necessary. Acquiring these skills is one of the most important tasks of the early childhood years.

**FAS – Fetal Alcohol Syndrome**: a permanent birth defect syndrome caused by maternal drinking during pregnancy. FAS is characterized by growth deficiency; a cluster of 3 minor facial abnormalities including a thin upper lip, a smooth philtrum (i.e., the groove between nose and upper lip); small eyes; and significant abnormalities in brain development. FAS is the leading preventable cause of intellectual disability and other neurodevelopmental conditions.

**FASD - Fetal Alcohol Spectrum Disorder**: Children whose mothers drank during pregnancy, and who have developmental impairment may be diagnosed with one of several FASDs. The developing brain is the organ most vulnerable to prenatal alcohol exposure, but the range of impact of prenatal alcohol exposure includes both physical and neurodevelopmental impairment. These can include growth difficulty, minor facial anomalies, general developmental delays, seizures, learning disabilities, ADHD, executive functioning and processing challenges, as well as mental health or behavioral challenges. The most severe FASD is Fetal Alcohol Syndrome (FAS – see FAS), but other FASDs are far more common.

**FBA - Functional Behavior Analysis**: The process of systematically determining the function of behaviors, usually inappropriate, that are displayed by people. Behaviors are defined, measured and analyzed in terms of what happened before and after their occurrence. Over time the events before and after the behavior occurs are systematically changed in order to determine the function of the behavior for the person displaying it.

**IEP- Individualized Education Program**: A written statement of a child’s current level of development (abilities and impairments) and an individualized plan of instruction, including the goals, the specific services to be received, the people who will carry out the services, the standards and time lines for evaluating progress, and the amount and degree to which the child will participate with non-handicapped peers at school. The IEP is developed by the child’s parents and the professionals who evaluated the child. It is required by the Individuals with Disabilities Education Act (IDEA) for all children in special education, ages three years and up.
IFSP - Individualized Family Service Plan: A written plan describing the infant’s or toddler’s current level of development, the family’s strengths and needs related to enhancement of the infant’s or toddler’s development, goals for the child and the other family members (as applicable), including the criteria, procedures and time lines used to evaluate progress (the IFSP should be evaluated and adjusted at least once a year and reviewed at least every six months), and the specific early intervention services needed to meet the goals (including the frequency and intensity and method of delivering services, the projected date of initiating services and the anticipated duration of services). The IFSP is developed and implemented by the child’s parents and a multidisciplinary early intervention team (IFSP Team). The Individualized Family Service Plan is required by the Individuals with Disabilities Education Act (IDEA) for all infants and toddlers receiving early intervention services.

IDEA - Individuals with Disabilities Education Act: The federal law reauthorized in 2004 that amends the Education for All Handicapped Children Act (Public Law 94-142). Part C of the law focuses on services to infants and toddlers who are at-risk or have developmental disabilities.

Intellectual Disability: Characterized by significantly impaired intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

Language disorder: In children, this could mean trouble getting their meaning or message across to others (expressive language disorder), or understanding messages coming from others (receptive language disorder), as well as difficulty using language to get things done (pragmatic language/social communication disorder).

Learning disability: A disorder that affects how a person learns and understands primary skills such as reading, writing and math.

LRE - Least Restrictive Environment: The educational setting that permits a child with disabilities to derive the most educational benefit while participating in a regular educational environment to the maximum extent appropriate. It is presumed that a child with a disability will be educated in the general education classroom, with appropriate supports, unless the IEP Team deems another setting as more appropriate. LRE is a requirement under the IDEA.

Motor Skill: The learned ability to perform movements, such as holding the body upright to sit, using the hands to manipulate small items, scooping food onto a spoon and bringing it to the mouth, and moving the lips and tongue to articulate different sounds. Fine motor skills involve
use of the small muscles of the body while gross motor skills are associated with large muscle movements.

N

NICU – Neonatal Intensive Care Unit: Also known as an intensive care nursery (ICN), the NICU is an intensive care unit specializing in the care of ill or premature newborn infants.

Nonverbal Communication: Any form of or attempt at unspoken or “physical” communication. Examples are temper tantrums, gestures, pointing and leading another person to a desired object.

Nutritionist: Nutrition services are provided by Registered Dietitian Nutritionists (RDNs). The nutritionist evaluates the child’s growth, energy intake, and nutritional status to make sure they are getting appropriate nutrients from their diet. Often, a nutritionist will work with a feeding therapist (e.g., speech or occupational therapist), to develop a plan when feeding problems are suspected.

O

OT- Occupational Therapist: Is a skilled healthcare provider that assists people across the lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Occupational therapy benefits individuals who have physical, developmental or cognitive limitations. With children, treatment is geared toward development of fine motor skills (e.g. writing, cutting), gross motor skills (e.g. climbing stairs, jumping), self-care (e.g. dressing, eating), and play. OT is the primary profession that addresses sensory processing differences.

P

Prematurity: A premature birth is a birth that takes place more than three weeks before a baby is due. Normally, a pregnancy lasts about 40 weeks so a premature birth is one occurring before the start of the 37th week of pregnancy.

Psychologist: Someone with a PhD or PsyD, trained in the evaluation, study and/or treatment of psychiatric and cognitive disorders. A school psychologist is professional trained in psychology and education that collaborates with children, educators, parents and other professionals to create healthy and supportive learning environments for students based on careful evaluation of cognitive, executive, and adaptive skills.

PT - Physical Therapist: Is a health care team member who treats conditions that limit the ability to move and perform functional activities of daily life. Physical therapists provide services to improve body structures (e.g. muscles), enhance functional activities (e.g. walking), and promote
improved participation in daily life. Goals for children may include developing improved strength, range of motion, coordination, balance, and acquisition of new motor skills.

**PKU- Phenylketonuria:** Is an inherited disorder that increases the levels of a substance called phenylalanine in the blood. Phenylalanine is found in food proteins and in some artificial sweeteners. If PKU is not treated, phenylalanine can build up to harmful levels in the body, causing intellectual disability and other serious health problems such as seizures, delayed development, behavioral problems, and psychiatric disorders.

**R**

**Red Flags:** Behaviors that cause caregivers concern in an area of a child’s development. They should warn you to stop, look, and think, and then observe and document.

**S**

**Screening test or tool:** An evaluation tool designed to identify children who are at-risk for having or developing a developmental disability. This is different from a diagnostic tool that is used to determine if a person has, or does not have a neurodevelopmental disability.

**Sensory Processing Disorder:** Refers to difficulty detecting, organizing, or responding to sensory information received and interpreted in the brain via all seven senses and that interferes with participation in daily life, development, behavior, and social interactions.

**Social communication disorder:** Applies to children who have deficits in the social use of language, but do not have the restricted interests or repetitive behavior commonly found in autism spectrum disorders.

**Social reciprocity:** The primary component of healthy social development – acts of kindness - interactions. It is about “joint attention” where there is purposeful language including body language and pretend play. Lack of social reciprocity is a key red flag, whether the child is not engaged in the world around him – this concern should not be ignored.

**Social Worker:** Social work practice is aimed at assisting individuals, groups, or communities to enhance or restore their capacity for social functioning and creating societal conditions favorable to reach their goals. The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.

**Specific learning disability:** A disorder that manifests itself with a deficit in areas such as attention, reasoning, processing, memory, communication, reading, writing, spelling, calculation, coordination, social competence and emotional maturity. Often identified by a discrepancy between school performance and the performance expected based on overall intelligence.
Speech-language Pathologist: A clinician who assesses, diagnoses, treats, and helps prevent speech, language, cognitive, communication, voice, swallowing, fluency, and other related disorders.

Speech sound disorder: Speech disorders in which some speech sounds in a child’s native language are not produced, not produced correctly, or are not used correctly.

Standardized test: A test administered and scored in a consistent or standard manner is a standardized test. It is administered in controlled conditions that specify where, when, how, and for how long children respond to the questions. In standardized tests, the questions, conditions for administering, scoring procedures, and interpretations are consistent. A well designed standardized test provides an assessment of an individual's mastery of a domain of knowledge or skill.

Transition Plan/Transition Services: Part of IDEA, transition services means a coordinated set of activities for a child with a disability that is results-oriented and focused on improving the academic and functional achievement of the child with a disability in order to facilitate the child’s movement from school to post-school activities, including postsecondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. Transition services will be based on the individual child’s needs, taking into account the child’s strengths, preferences, and interests.

Glossary adapted by John Thorne, PhD, CCC-SLP, from a number of in-depth resources (12/16) including:

http://www.inclusivechildcare.org/inclusion_glossary.cfm


http://www.ncca.biz/Aistear/pdfs/PrinciplesThemes_ENG/Glossary_ENG.pdf

http://www.johnson-center.org/downloads/pdfs/What_is_a_Standardized_Test.pdf