

ESIT (Birth-to-3) Team Input

Thank you for completing this form! It is designed to support the diagnostic evaluation process by getting information from the child's ESIT team about specific behaviors related to a diagnosis of autism. Please note that portions of this may be shared with the family verbally or in the report, so please **make a note if something is meant to be confidential.**

Today's Date: _____

Child's Name: _____

DOB: _____

Person(s) Completing Form

Name			
Role			
Email Address			
Phone Number			

Please check all ESIT services that this child currently receives:

Special Instruction Speech OT Physical Therapy Infant Mental Health

Other (specify): _____

Please describe notable strengths of this child and family:

Select the following behaviors related to a diagnosis that your team is *currently* seeing:

Details (of those chosen or others not included):

Communication:

- No attempts to communicate/
Doesn't seem to understand they can do so
- Repetitive/unusual vocal (including echo/stereotyped)
- Back and forth communication
- Word approximations/no single words
- Simple words
- Simple phrases

<p>Play:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Does not play with toys <input type="checkbox"/> Lines up toys <input type="checkbox"/> Plays with only parts of toys <input type="checkbox"/> Closely examines things <input type="checkbox"/> No pretend play <input type="checkbox"/> Does not invite others to play <input type="checkbox"/> Ignores the invitations of others <input type="checkbox"/> Prefers to play alone 	
<p>Social:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Limited response to name <input type="checkbox"/> Limited eye contact <input type="checkbox"/> Limited sharing interests (showing, pointing things out) <input type="checkbox"/> Treats unfamiliar and familiar people similarly <input type="checkbox"/> Difficult to engage 	
<p>Sensory:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Explores new places and things with mouth <input type="checkbox"/> Very sensitive to textures/sounds <input type="checkbox"/> Food aversions <input type="checkbox"/> Seeks sensory input 	
<p>Other:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Toe walking <input type="checkbox"/> Hand flapping <input type="checkbox"/> Other repetitive body movements <input type="checkbox"/> Difficulty with transitions <input type="checkbox"/> Distress with change <input type="checkbox"/> Ritualistic <input type="checkbox"/> Very focused on topic/specific objects 	
<p>How is the family approaching an autism evaluation and possible diagnosis?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hesitant <input type="checkbox"/> Anxious/Nervous <input type="checkbox"/> Not ready - Only doing this because they were told to <input type="checkbox"/> Couple is in conflict - One wants is ready, one is not <input type="checkbox"/> Ready - Parents want to find out if their child meets the criteria for autism <input type="checkbox"/> Other (please explain) 	

<p>How do you anticipate parent(s) would respond to diagnosis?</p> <p><input type="checkbox"/> Relief</p> <p><input type="checkbox"/> Feel supported</p> <p><input type="checkbox"/> Feel empowered to move to the next step</p> <p><input type="checkbox"/> Shock/ withdrawal/disbelief</p> <p><input type="checkbox"/> Sadness</p> <p><input type="checkbox"/> Acceptance/Positive Thinking</p> <p><input type="checkbox"/> Anger</p> <p><input type="checkbox"/> Self-blame</p> <p><input type="checkbox"/> Worry/Anxiety</p> <p><input type="checkbox"/> Other (please explain)</p>	
<p>Is there anything else we should know about this child and family? (Please explain)</p> <p><input type="checkbox"/> Trauma</p> <p><input type="checkbox"/> Homelessness</p> <p><input type="checkbox"/> Language/Cultural Practices</p> <p><input type="checkbox"/> Financial Barriers</p> <p><input type="checkbox"/> Relationship Challenges</p> <p><input type="checkbox"/> Other (please explain)</p>	
<p align="center">Team's Overall Impression of the Likelihood that this Child has ASD</p> <p align="center"><input type="checkbox"/> Mild/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> High*</p> <p align="center">Family's Overall Impression of the Likelihood that the Child has ASD**</p> <p align="center"><input type="checkbox"/> Mild/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> High*</p> <p><i>*Note: Cases considered High likelihood by both team and family may qualify for expedited evaluation.</i></p> <p><i>**Note: This is just meant to be a way for us to tell if the family sees their child as Autistic already, etc.</i></p>	
<p>How can we best support your work with this child and family?</p>	

Thank you for taking the time to complete this form!