On-Time Autism Intervention
UNIVERSITY of WASHINGTON

ESIT (Birth-to-3) Team Input

Organization: _____ 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 explain any change in type or intensity of services since the child started ESIT services:

Select all the behaviors 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) ☐ Lack of conversation skills ☐ Word approximations/no single words ☐ Simple words ☐ Simple phrases	
Play: ☐ Does not play with toys ☐ Lines up toys ☐ Plays with only parts of toys ☐ Closely examines things ☐ No pretend play ☐ Does not invite others to play ☐ Ignores the invitations of others ☐ Prefers to play alone	

Social: ☐ Limited response to name ☐ Limited eye contact ☐ Limited sharing interests (showing, pointing things out) ☐ Treats unfamiliar and familiar people similarly ☐ Difficult to engage	
Sensory: ☐ Explores new places and things with mouth ☐ Overly sensitive to textures/sounds ☐ Food aversions ☐ Seeks sensory input	
Other: ☐ Toe walking ☐ Hand flapping ☐ Other repetitive body movements ☐ Difficulty with transitions ☐ Resistance to change ☐ Ritualistic ☐ Overly focused on topic/specific objects	
How is the family approaching an autism evaluation and possible diagnosis? ☐ Hesitant ☐ Anxious/Nervous ☐ Not ready - Only doing this because they were told to ☐ Couple is in conflict – One wants is ready, one is not ☐ Ready - Parents believe their child has ASD ☐ Other (please explain)	
How do you anticipate parent(s) would respond to diagnosis? ☐ Denial/Refusal to accept ☐ Sadness ☐ Acceptance/Positive Thinking ☐ Anger ☐ Self-blame ☐ Worry ☐ Other (please explain)	

Is there anything else we should know about this child and family? (Please explain) ☐ Trauma ☐ Homelessness ☐ Language/Cultural Barrier ☐ Financial Barriers ☐ Relationship Challenges ☐ Other (please explain)	

Team's Overall Impression of the Likelihood that this Child has ASD

☐ Mild/Minimal ☐ Moderate ☐ High*

Family's Overall Level of Concern for the Child having ASD

☐ Mild/Minimal ☐ Moderate ☐ High*

**Note: Cases considered High likelihood by both team and family may qualify for expedited evaluation.*

Strengths of Child and Family:

How can we best support your work with this child and family?

Thank you for taking the time to complete this form!