Center for Autism and Pervasive Developmental Disorders
Clinic Application

Please return this application, along with copies of the following materials on your child, if applicable, to:

CSAAC's Center for Autism and PDD (CAPDD)
Attn: Kay Inoue, Program Manager
21515 Zion Road, Brookeville, MD 20833.

Psychological Evaluation, Speech and Language Evaluation, Treatment reports/Workshop reports, Individualized Education Program, and Medical Evaluation reports (including physical exam and immunization records).

ALL INFORMATION IS CONFIDENTIAL AND FOR CSAAC USE ONLY!

1. Personal Information

Child's Name: ____________________

Child's Home Address: ____________________

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Date of Birth: ____________________

Circle one: Male / Female

Mother's Name: ____________________

Mother's Address: ____________________

Home telephone: ____________________

Work telephone: ____________________

Cell phone: ____________________

Email address: ____________________

Father's Name: ____________________

Father's Address: ____________________

Home telephone: ____________________

Work telephone: ____________________

Cell phone: ____________________

Email address: ____________________

Other Caretaker's Name(s): ______________________________

Contact information: ______________________________

Relationship to child: ______________________________

2. Medical History

Has you child been diagnosed with Pervasive Developmental Disorder, Autism, or other related condition? If yes, please provide information below and provide a copy of the most recent evaluation:

Type of evaluation	Date	Evaluator	Institution	Diagnosis (if any)

Please list any significant medical conditions that your child has and name and phone of physician making diagnosis:

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Please list any prescribed medications that your child is currently taking (long-term) or has taken in the past and indicated the name of the prescribing physician:

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Is your child covered by medical insurance?___________________
If yes, please provide the following information:

Name of insurance carrier:____
Identification #:____
Name of policy holder:____
Phone contact for insurance:_______________________________________
Expiration date:____

3. Therapy and/or Educational Service History

1. Has your child previously received one-to-one behavioral intervention?_____________
   If yes, please answer the following questions:

   Who was the workshop leader or behavior consultant?

   Name:____________________________________

   Institution:_________________________________

   What was the date of you initial workshop?______________________
   How many hours of one-to-one therapy did your child receive per week? ________
   When was the last day of therapy with this consultant or institution? ____________

   Why was therapy discontinued? ____

   On average, how frequently have you held follow up workshops? ___________________

   Please list all of your child's current/past programs:

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Please list all of your child's maintenance programs and indicate the date that the program was put on a maintenance schedule:

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2. Please list any other autism-related services that your child currently receives or has received in the past and indicated when the treatment began, the frequency, and duration of the treatment. Also indicated whether your child is still receiving the service:

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3. Has your child been referred and approved for funding in CSAAC's IEI Program by your county school administration? ______________________________

   School Contact person:______________________________

   Phone:______________________

4. If not, please indicate the steps, if any, you have taken to secure funding through your school district and the current status of funding for intensive early intervention:

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5. Does your child attend daycare, preschool, play group, or other part-time child care with other children?__________If yes, please complete below:

   Name of facility:______________________
   Address:__________________________
   ____
   Phone #:__________________________
   Contact person:______________________