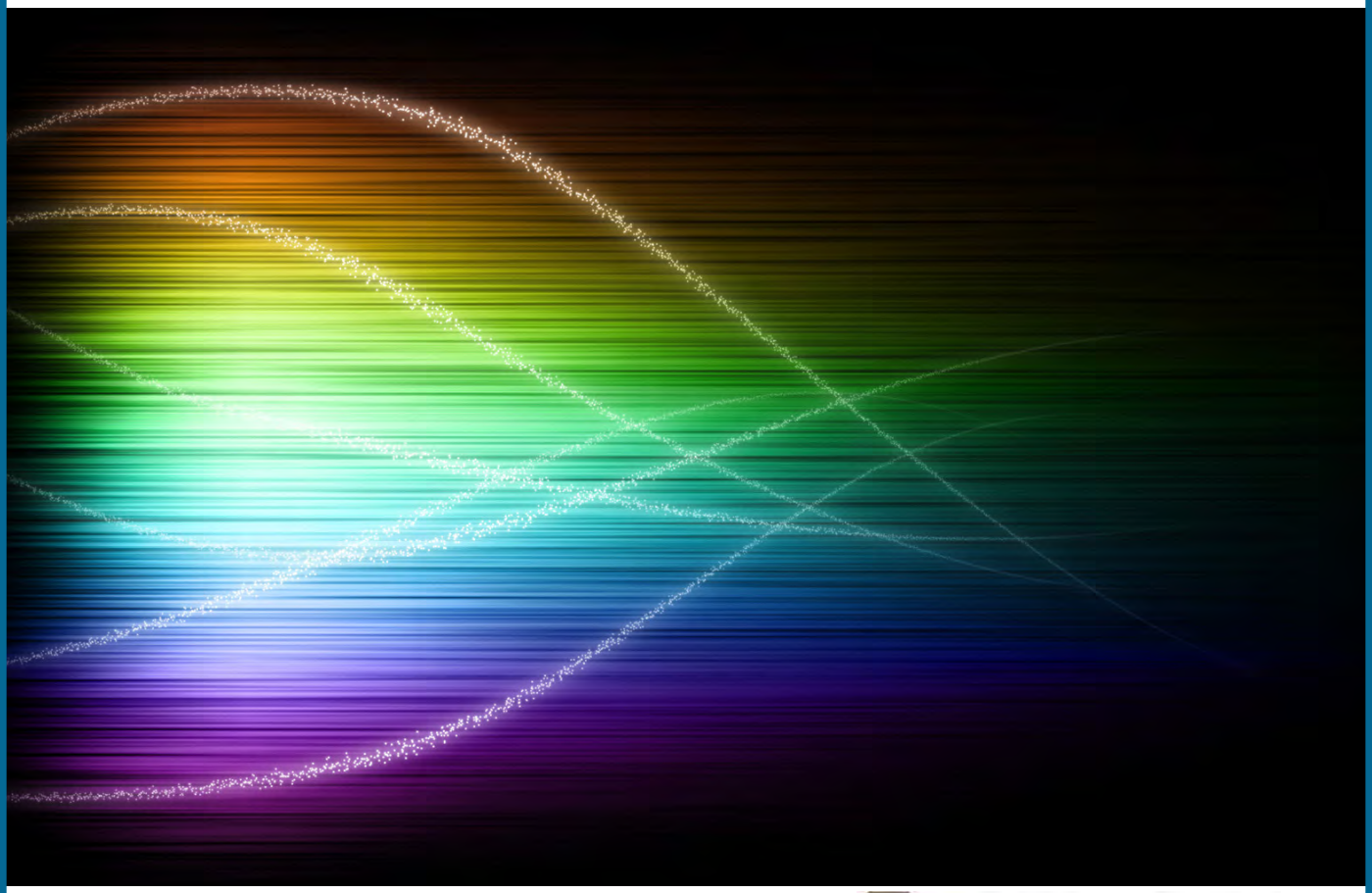
Guidelines for the Educational Evaluation of Autism Spectrum Disorder

Exceptional Student Services Unit

The Office of Special Education

February 2014



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Acknowledgments

Sincere appreciation is extended to the many members of the Colorado Department of Education (CDE) State Autism Task Force and JFK Partners who have contributed their time, extensive knowledge and expertise to develop this document. The CDE State Autism Task Force is composed of individuals representing the Colorado Department of Education, school administrators, related service professionals, educators, higher education faculty, families, advocates and community agencies. The goal of the Autism Task Force is to provide guidance and support to CDE for improving the education of individuals with ASD across the state.

Thanks to Autism Speaks, who funded some of our team's time in developing this document and other online tools referenced in this document, through the Global Autism Public Health Initiatives. For more information, see www.autismspeaks.org.

Finally, we are especially grateful to the Colorado school districts and Board of Cooperative Educational Services, (BOCES) for the ongoing discussions and collaboration we have had regarding the educational identification process.

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Table of Contents

Introduction 4

Section I: Background

1.1 Overview of Autism Spectrum Disorders (ASD) 6

1.2 Colorado's Eligbility Criteria for Autism Spectrum Disorder 10

1.3 Overview of the ASD Educational Evaluation Process in Colorado 14

Section II: Conducting an Evaluation for ASD

2.1 Detect 16

2.2 Refer 16

2.3 Screen 17

2.4 Evaluate 18

2.5 Collaborate 20

2.6 Activate 21

2.7 Case Study 21

Section III: Supporting Documents 24

Introduction

This guidance document has been developed to assist school district personnel and families in becoming familiar with the wide range of characteristics and abilities of their students with an autism spectrum disorder (ASD) and in applying Colorado's new eligibility category of Autism Spectrum Disorder (ASD) to identify students eligible for special education services. Schools have experienced a steady increase in the number of students with autism spectrum disorder over the past 10 years. In 2012 the Center for Disease Control (CDC) estimated that about 1 in 88 young children have an ASD. The information in these guidelines may be used to guide the process of identifying students with ASD and developing appropriate programming, supports and services.

The Colorado Legislature amended the state Rules for the Administration of the Exceptional Children's Education Act (ECEA) through House Bill 11-1277 in 2011. The Colorado State Autism Task Force and a CDE statewide stakeholder's group co-developed the definition and criteria, which were passed by the Colorado State Board of Education in summer 2012 and became effective in ECEA Rules in October 2012. The current definition of Autism in the Individuals with Disabilities Education Act (IDEA) was written in 1992 and was based on the definition of Autistic Disorder in the Diagnostic and Statistical Manual – IIIR which has since been through several revisions. Colorado's definition expands on the IDEA definition based on the expertise of the CDE Autism Task Force members and the extensive research by contributors from JFK Partners at the University of Colorado, School of Medicine.

This is a "living document," which will continue to be revised as new information becomes available. The text of this document includes links to websites that provide a deeper level of content in various multimedia formats. Words underlined and in blue are hyperlinked. To go to the website, hold the control key and click on the word or phrase.

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Practices identified in these Guidelines are particularly relevant for:

- Administrators responsible for implementing IDEA
- Members of Child Find teams evaluating children under the age of six years
- Members of IEP or Evaluation Teams across all grade levels: preschool-high school
- Families of children and youth being evaluated for ASD

This document, including all supporting documents, has been vetted by the Colorado State Autism Task Force and the Colorado Department of Education. Permission is granted for the reproduction and use of this document by Administrative Units for educational purposes.

Introduction

Content for this document was developed from the following sources:

1. A review of evidence-based practices for educational evaluations (with a particular emphasis on those focused on identifying ASD).

2. A review of developmental science in ASD (in order to be specific about which features are likely to be evident at different ages and developmental levels).

3. A review of IDEA sources; including legal summaries, policy papers, guidelines from other states across a range of eligibility categories.

4. Discussions with school professionals in Colorado from 2002-2012, who serve in various roles within a school's community (e.g., general educators, special educators, administrators, speech-language pathologists, school psychologists, occupational therapists, paraprofessionals, nurses, etc.) and work with students across the age range of preschool to transition.

5. Discussions with Child Find Team Members and early interventionists from the Birth-to-Three (Part C) Systems across the state.

6. Discussions with families who have participated in an educational evaluation process

7. A review of the transcripts from the Colorado Statewide Autism Commission stakeholders meetings held around the state between 2007 and 2010.

8. Discussions with the Autism Task Force Members and participants in CDE-sponsored trainings in ASD identification conducted between 2005 and 2012.

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Section I: Background

1.1 Overview of Autism Spectrum Disorders (ASD)

Autism spectrum disorder (ASD) refers to a behaviorally defined neurodevelopmental disability characterized by qualitative impairments of social reciprocity, nonverbal and verbal communication and flexibility in thoughts and actions. Recently described as a "disconnectedness syndrome" (Geschwind & Levitt, 2007), ASD is considered to be a biologically based condition involving differences in how parts of the brain and nervous system interact and develop over time. Although biological in nature, the exact causes are not yet known. At the present time, there is no medical test for ASD, and the only available way to determine if a child has an ASD is to look for a certain pattern of gaps or unevenness in the development of social interaction, communication and restricted patterns of activities and interests relative to the child's overall developmental level.

Autism spectrum disorder is a developmental disorder, meaning that the child's pattern of growth across areas of development is uneven, with different skills growing at different rates than each other. For example, a 2-year old child with ASD may be decoding words in books, but not speaking spontaneously. Some skills even seem to develop in a different sequence than in typically developing children. For example, imitation skills develop on a different timeline and in a different set of steps in children with ASD than in typically developing children or those with global developmental delays (Rogers S. J., et al, 2010). Young children, who later received a diagnosis of ASD, imitated with objects first, whereas children with other developmental delays (and those developing typically) imitate gestures and body movements first. Another example is the relatively frequent report of young children with autism spectrum disorder skipping some of the "pre-walking" stages (such as walking while holding onto something) when taking their initial steps. The duration of developmental phases may also be different in ASD – for example, while typically developing children go through a phase of echoing what other people say during the toddler years (called "echolalia"), a child with ASD may continue to echo others across childhood and into adulthood.

ASD is a "spectrum disorder." That means ASD affects each person in different ways, and can range from very mild to severe. People with ASD share some similar symptoms, such as problems with social interaction, but there are differences, such as the age of onset, severity, and the presentation of symptoms. Therefore, the overall presentation will vary from child to child.

A child with a history of evenly developing skills, that appear to follow the expected developmental sequence, but with slower rates of skill acquisition, is usually described as a child with a developmental delay; not a disorder.
In contrast, a child with a history of unevenly developing skills, that appears to follow an unexpected developmental sequence, with different rates of skill acquisition across different skills is usually described as a child with a developmental disorder; not a developmental delay.

ASD begins in early childhood and lasts throughout a person's life, although symptoms may improve over time. Some children with ASD show hints of future problems within the first few months of life. In others, symptoms might not show up until 24 months or later. Some children with ASD seem to develop typically until around 18 to 24 months of age and then they stop gaining new skills, or they lose the skills they once had (Centers for Disease Control, March 2012).
The way in which a particular child with ASD presents is likely to differ depending on:

- Chronological age
- Developmental level
- Pattern and severity of behaviors associated
- Overall intellectual potential and strengths/concerns
- Learning style including attention skills
- Receptive and expressive language skills
- Physical health and well-being (e.g., absence/presence of seizures, allergies/autoimmune concerns, sleeping/eating/toileting concerns, access to exercise, etc.)

For most children, symptoms arise in the first three years of life. Most families report being concerned around 16-24 months, usually becoming worried about a lack of development of language. Approximately 30% of toddlers with ASD go through a brief period during the second year of life where they no longer use words they once had, or where they do not seem to be gaining new words and communicative skills (Ozonoff S. et al, 2008).

At this time, there is no known cause for autism spectrum disorder. Researchers are investigating a number of theories and most believe there will not be one single cause but a number of pathways to an ASD including genetics, heredity, environment and medical problems. Currently, no single gene or gene segments or environmental factors have been identified. Literature on brain scan research has shown that there are "structural and functional abnormalities

of the brain. They are seen as cognitive and neurological abnormalities that are ultimately manifested as behavioral differences" (Minshew & Williams, 2007). While individuals with ASD can improve markedly over time, there is no known cure for this set of conditions. Early intervention can improve both developmental functioning and the quality of life for the individual and his or her family (Eikeset, Smith, Jahr, & Eldevik 2007; Howlin, 2008; Rogers & Vismara, 2008). The most effective interventions at the present time are educational, behavioral, and communicative.

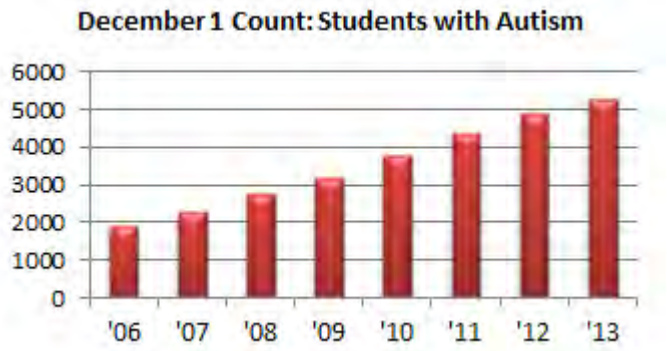
There has been a steady increase in the incidence rate for ASD since the mid-1990s. The Centers for Disease Control and Prevention (CDC) reported that 1 in 88 young children have autism spectrum disorder (CDC, 2012). There are several factors that are involved in the reported increase including (a) expanding the definition from autism to autism spectrum disorder, (b) increasing knowledge of the disorder by professionals which leads to an increase in diagnosing, (c) more consistency by CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network in the method used to count and (d) an actual increase in the rate of children being born with the disorder. Administrative Units in Colorado have also felt the impact of this increase.

These data in the above chart do not reflect all of the students with ASD being served in Colorado public schools. Several factors influence these data. Our young students with ASD may have been counted as a Preschool Child with a Disability. A child with a co-occurring emotional disorder may have been determined to have a Significant Identifiable Emotional Disability. Or a student may currently have the label of Physical Disability. Finally, students without a diagnosis that attended an AU that did not educationally identify students with ASD may be receiving services under other disability categories, such as speech or language impairment or significantly limited intellectual capacity. As the new disability categories, described in the next section begin to be implemented, there will be a possible effect on the data.

Most individuals with ASD face one or more additional challenges, including learning disabilities, psychiatric conditions, difficulties with sleeping, eating, regulating behaviors, and attending to an activity or conversation in an appropriate way. Researchers are also investigating co-occurring medical conditions, which have been observed in some individuals with this complex condition, such as immune system irregularities, endocrine disorders, neurological conditions (such as seizures), and gastrointestinal disorders (Coury, 2010).

There are three core areas of development that are central to an ASD:

1. **Impairments in Social Reciprocity** (i.e., the spontaneous ability to engage in back-and-forth social interactions with a variety of people in a variety of situations is awkward or



missing). Some children with ASD may appear as "aloof" or "in their own world." They may persist in avoiding social contact with unfamiliar people in a manner that cannot be explained by shyness or fear. Others may seem socially interested, but have a very passive style, appearing to not know how to start or maintain interactions with others.

Alternately, some children appear socially active and engaged in the flow of interactions, but their social style is experienced by others as "one-sided," "awkward," or "intrusive." For many children with ASD, interacting with adults (particularly familiar and/or responsive adults) is much easier than playing with their peers. For many of these children, it isn't until school entry when their social challenges become apparent.

2. **Lack of Communicative Competence** (i.e., the child lacks the ability to send and receive messages to others in a fluid and integrated manner). This core category includes delayed or disordered speech, integration of nonverbal behaviors into attempts to communicate (such as using a coordinated eye gaze, pairing gestures with sounds, using an appropriate voice tone and maintaining an appropriate proximity to others when communicating), as well as communicating for a range of social purposes (such as maintaining a conversation, asking for assistance, sharing observations and information).

   For some highly verbal children with ASD, speech develops typically, however, learning how to communicate with others in a socially appropriate way can be challenging. This aspect of communication is referred to as pragmatics and is considered an educationally relevant aspect of adaptive behavior.

3. **Restricted, Repetitive Patterns of Behavior, Interests or Activities** (i.e., the child may demonstrate a strong preference for familiarity, routines, and an insistence on sameness in activities and behaviors). This core category can be evident through repetitive motor behaviors (such as hand-flapping or jumping and pacing), repetitive play with objects (such as lining up toys but not really playing "with" them). There may also be a "driven" desire for specific routines and/or rules to be followed, or an intense preoccupation with one interest, toy or part of an object, without really seeing the "big picture." "Getting stuck" or "perseverating" also describes this core category.

"Red Flags" of ASD at Different Ages	
AGE OF CHILD	POSSIBLE SIGNS OF ASD INCLUDE BUT ARE NOT LIMITED TO:
Birth to 12 months (Infancy)	• No babbling or fewer vocalizations with a limited range of sounds • No pointing or gesturing • "Out of sync" with caregiver • Doesn't smile at people • Delayed response to name • Poor social orienting
12 to 36 months (Toddlerhood)	• No single words by 16 months • No spontaneous 2-word phrases by 24 months • Any signs of loss of language or social skills • Lack of response to name • Poor coordination of eye gaze with other communicative behaviors (such as gestures) • Lack of spontaneous imitation • Failure to follow another person's point towards an object or event of interest • Lack of shared enjoyment • Doesn't respond to name • Limited repertoire of play activities
3 Years	• Doesn't understand simple instructions • Doesn't speak in sentences • Doesn't make eye contact • Doesn't play pretend or make-believe • Doesn't want to play with other children • Interest in parts of objects • Play preference for objects over people
4 Years	• Has trouble scribbling • Shows no interest in interactive games or make-believe • Ignores other children or doesn't respond to people outside the family • Resists dressing, sleeping and using the toilet • Doesn't understand "same" and "different" • Doesn't use "me" and "you" correctly • Doesn't follow 3-part commands • Cannot retell a favorite story
5 Years	• Doesn't show range of emotions • Shows extreme behavior (unusually aggressive, shy or sad) • Unusually withdrawn and not active • Is easily distracted, has trouble focusing on one activity for more than 5 minutes • Doesn't respond to people, or responds only superficially • Cannot tell what's real and what's make-believe • Doesn't play a variety of games and activities • Cannot give first and last name • Doesn't use plurals or past tense properly • Doesn't talk about daily activities or experiences • Doesn't draw pictures • Cannot brush teeth, wash and dry hands or get undressed without help

"Red Flags" of ASD at Different Ages	
AGE OF CHILD	POSSIBLE SIGNS OF ASD INCLUDE BUT ARE NOT LIMITED TO:
5 - 11 Years (Elementary School)	• Difficulty making friends • Limited social reciprocity (i.e., spontaneous, fluid, back-and-forth social interaction, with changes in social behaviors as a result of changes in one's social partners' behavior or changes in the social context) • Limited understanding of social rules/conventions (i.e. may not use eye gaze during conversation or may not shift gaze away from partner, does not use gestures to emphasize meaning in conversation) • Limited understanding of other peoples' feelings and perspectives (Theory of Mind) • Nonverbal behaviors tend to be less well-coordinated; less "natural" and fluid • If verbal, language tends to be unusual (i.e., formal, repetitive, pedantic, may use made-up words, may repeat scripts - or memorized bits of dialogue heard in movies or books - to self or with others • Limited play skills • Tendency to focus on a particular interest or topic • Strong preference for routine and predictability • Anxious, which may look like behaviors, particularly around anything new or is a change • Preoccupation with rules, fairness & justice
12 - 18 years (Middle & High School)	• Lack of insight (particularly with regard to social relationships, social conventions, and sense of personal responsibility • Discrepancy between intellectual potential and competence in self-care • Difficulty understanding the nonverbal cues of others in a rapid, automatic fashion • Unusual prosody (i.e., rate, rhythm and volume of speech, modulation of voice to express emotion) • Difficulty with executive functioning: organization, goal setting, planning, initiation, decision making, etc. which adversely impacts school work • Misinterprets others intentions • Restricted range of interests and activities

Other features of ASD that are present across the school years are:

- Rigidity in thinking, difficulty shifting from a thought, idea or expectation
- Over-selective attention focusing on detail but may not see the overall concept
- Socially naive, does not understand the intentions of others

To learn more about how ASD symptoms present in children of different ages, explore the online educational modules, which include videotaped examples of children with and without ASD, as well as more information on what to look for: First Signs ASD Video Glossary or the Autism Speaks Video Glossary . More resources are located in Section III.

1.2 Colorado's Eligibility Criteria for Autism Spectrum Disorder

1. **What does the Individuals with Disabilities Education Act (IDEA) say about educational identification?**
   IDEA specifically includes an eligibility category for "Autism," which is intended to include children who present with impairments in social interactions, nonverbal communication, and an inability to adapt easily to new experiences and changes in expectations. See Box 1 for the IDEA definition of Autism.

Box 1: Definition of Autism in IDEA

§300.8 (1)(i) *"Autism" means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three that adversely affects a child's educational performance. Other characteristics often associated with autism are engaging in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. The term autism does not apply if the child's educational performance is adversely affected primarily because the child has an emotional disturbance. A child who shows the characteristics of autism after age 3 could be diagnosed as having autism if the criteria above are satisfied."*

2. **What is meant by "adversely affect a child's educational performance"?**
   IDEA does not use "academics" to define educational performance. According to the law, the purpose of special education is "to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living even if the child has not failed or been retained in a course or grade, and is advancing from grade to grade." [§300.101(c)(1)] The social and communication, as well as, other deficits of ASD must also be assessed. Standardized assessments alone cannot determine educational performance but consideration must be on the functioning level within the school environment.
   OSEP's guidance on the meaning of "educational performance"

"The term 'educational performance' is not defined in IDEA or in the regulations, and OSEP has consistently chosen not to define it. Instead, OSEP directs school officials to consider both academic and nonacademic skills and progress in determining whether a child's impairment adversely affects his or her educational performance: "The assessment is more than the measurement of the child's academic performance as determined by standardized measures."
Letter to Lillie/Felton, 23 IDELR 714 (OSEP 1994).

3. **What does Colorado law say about educational identification?**
   The Colorado Board of Education recently amended the Rules for the Administration of the Exceptional Children's Education Act (ECEA) to align with IDEA by making Autism Spectrum Disorder its own disability category with its own definition and criteria, separate from "Physical Disability". The new eligibility category for ASD is found in two sections: ECEA 2.08 (1) provides the definition and ECEA 2.08(1)(a) – 2.08(1)(b)(vi) sets out the disability criteria. See Box 2 for the ECEA Rules definition of ASD.
   To meet criteria for eligibility for special education under the ASD category, a student must demonstrate qualitative impairments in social interaction, communication and repetitive activities and/or restricted interests AND those impairments must make an observable impact on the student's functioning in the educational setting to the degree that specialized instruction is needed.

4. **How are an educational identification and a medical/clinical diagnosis different?**
   An educational identification of autism spectrum disorder is not the same as a medical or clinical diagnosis. Educational and medical/clinical systems have different goals, use different criteria for what constitutes "autism," employ different methods of evaluation, and conduct evaluation activities in different settings. See Box 3 for the DSM-5 definition of ASD.

4a. If a student has a medical diagnosis of an autism spectrum disorder, is he or she automatically eligible for special education services under the category of "Autism Spectrum Disorder?"
A medical/clinical diagnosis of an ASD does not directly translate into eligibility for special education under the ASD category. If medical information is available it should be considered as part of the assessment information that is reviewed during the educational eligibility process; however, the student's educational team (including his or her family/guardian) determines the appropriate, if any, educational eligibility category for the individual student.

> A medical diagnosis of an ASD does not translate directly into eligibility for an IEP. And, administrative unit personnel may not require a medical diagnosis before determining a student eligible for special education services.

Box 2: ECEA Rules: Definition of ASD

2.08 (1) A child with an Autism Spectrum Disorder (ASD) is a child with a developmental disability significantly affecting verbal and non-verbal social communication and social interaction, generally evidenced by the age of three. Other characteristics often associated with ASD are engagement in repetitive activities and stereotyped movements, resistance to environmental changes or changes in daily routines, and unusual responses to sensory experiences.

2.08 (1) (a) The Autism Spectrum Disorder prevents the child from receiving reasonable educational benefit from general education as evidenced by at least one characteristic in each of the following three areas (i.e., subsections (a)(i) through (a)(iii), below):

2.08 (1) (a) (i) The child displays significant difficulties or differences or both in interacting with or understanding people and events. Examples of qualifying characteristics include, but are not limited to: significant difficulty establishing and maintaining social-emotional reciprocal relationships, including a lack of typical back and forth social conversation; and/or significant deficits in understanding and using nonverbal communication including eye contact, facial expression and gestures; and

2.08 (1) (a) (ii) The child displays significant difficulties or differences, which extend beyond speech and language to other aspects of social communication, both receptively and expressively. Examples of qualifying characteristics include, but are not limited to: an absence of verbal language or, if verbal language is present, typical integrated use of eye contact and body language is lacking; and/or significant difficulty sharing, engaging in imaginative play and developing and maintaining friendships; and

2.08 (1) (a) (iii) The child seeks consistency in environmental events to the point of exhibiting significant rigidity in routines and displays marked distress over changes in the routine, and/or has a significantly persistent preoccupation with or attachment to objects or topics.

2.08 (1) (b) The following characteristics may be present in a child with ASD, but shall not be the sole basis for determining that a child is an eligible child with ASD if the child does not also meet the eligibility criteria set out in subsection (a) of this rule, above.

2.08 (1) (b) (i) The child exhibits delays or regressions in motor, sensory, social or learning skills.

2.08 (1) (b) (ii) The child exhibits precocious or advanced skill development, while other skills may develop at or below typical developmental rates.

2.08 (1) (b) (iii) The child exhibits atypicality in thinking processes and in generalization. The child exhibits strengths in concrete thinking, awareness and judgment. Perseverative thinking and impaired ability to process symbolic information is present.

2.08 (1) (b) (iv) The child exhibits unusual, inconsistent, repetitive or unconventional responses to sounds, sights, smells, tastes, touch or movement.

2.08 (1) (b) (v) The child's capacity to use objects in an age appropriate or functional manner is absent or delayed. The child has difficulty displaying a range of interests or imaginative activities or both.

2.08 (1) (b) (vi) The child exhibits stereotypical motor movements, which include repetitive use of objects and/or vocalizations, echolalia, rocking, pacing or spinning self or objects.

4b. Is a medical or clinical diagnosis required for an educational identification of an ASD?

Administrative unit personnel may not require families to obtain a medical diagnosis of an ASD before proceeding with an educational evaluation and a medical or clinical diagnosis is not required for an educational identification of ASD. If a medical report or any other report from a community-based practitioner is available, it should be considered by the school team as part of the evaluation but should not be the only source of information.

4c. What is the difference between a medical diagnosis and an educational identification of an ASD?

Different criteria and outcomes: Educational identification and clinical diagnosis are two very different processes, which, as summarized in Table 1 below, rely upon different definitions of ASD and provide information for different contexts. The two systems are not directly translatable; although data obtained in one process ought to be disclosed in the other process, because the quality of both processes is largely dependent upon the scope and accuracy of the information obtained. Full disclosure is encouraged and ultimately decided upon by the child's family/guardian.

4d. How is the Diagnostic and Statistical Manual-5th Edition (DSM-5) definition similar to the criteria for eligibility for special education under the ASD category?

The revised definition provided in the DSM-5 is more similar to the educational definitions than previous versions.

Specifically:

- Both now include reference to the impact of ASD on daily functioning
- Both now acknowledge that there is a spectrum of difficulties and neither system attempts to subdivide into categories such as "Autistic Disorder", "Pervasive Developmental Disorder – Not Otherwise Specified" or "Asperger's Syndrome"
- Both acknowledge that the impairments emerge in early development
- Both include core difficulties in both verbal and nonverbal social communication
- Both include core difficulties in social interaction, although the DSM-5 is more specific about the forms of behaviors one might observe

Box 3: Medical Definition Autism Spectrum Disorder – From the DSM-5

Must meet criteria A, B, C, and D:

A. Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifested by all 3 of the following:

1. Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction,
2. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated-verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.
3. Deficits in developing and maintaining relationships, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people.

B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following:

4. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases).
5. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).
6. Highly restricted, fixated interests that are abnormal in intensity or focus; (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
7. Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).

C. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities)

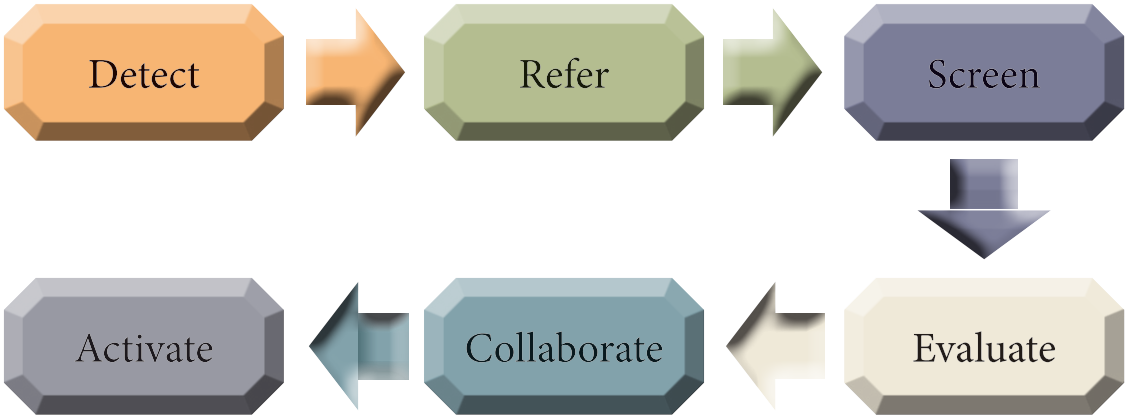
D. Symptoms together limit and impair everyday functioning.

Table 1: Differences Between Educational Identification and Clinical Diagnosis Of ASD

	EDUCATIONAL IDENTIFICATION	CLINICAL DIAGNOSIS
Source for definition of ASD in Colorado	IDEA/Colorado ECEA Rules	DSM-IV (APA, 2002) or DSM-5 (APA, 2013)
Decider: (i.e., who chooses the ED ID category?)	The Child Find or Individual Education Program (IEP) Team (which includes families, educational professionals and sometimes the student)	Psychologist, Psychiatrist or Physician
Time frame that applies	Evident & impairing right now, will be re-examined at least every 3 years	Lifelong, persistent condition, assumed to have been present in the past and assumed to be present in the future
Information included in the assessment or evaluation	• Academic achievement across several areas • Observation of behaviors in structured and unstructured school situations • Direct observation of social and communicative behaviors • Family interview for developmental and family history • Assessment of ASD characteristics • Teacher/Family report of problem behaviors and adaptive skills • May include: ◦ standardized assessments of intellectual functioning, language, motor skills, learning style, adaptive behaviors ◦ existing educational record and medical/ clinical reports, as provided by family	• Medical, family and developmental history • Caregiver reports of current functioning across settings • Direct observation of social and communicative behaviors • Further investigation into attention, mood or other aspects of mental health, as needed • Standardized assessments of overall intellectual functioning, speech & language, motor, and/or adaptive behaviors • May include: ◦ physical exam, genetics testing, ◦ neurological exam, or other relevant medical follow-up ◦ existing educational record and medical/ clinical ◦ reports, as provided by family
Cost to the family	Part of a free and appropriate public education	Estimated cost of $1,500 - $3,500 (sometimes covered by insurance, sometimes not)
Access to experienced professionals	Child Find and IEP team are always available (i.e., part of a free and appropriate public education); CDE provides training and guidance to administrative units (AU)on the educational evaluation for ASD.	Geographically dependent: Qualified/trained diagnosticians often practice in metropolitan areas and rural/frontier counties may not have any medical or mental health professionals with experience in clinical diagnosis of ASD.
Wait-time	Up to 60 days to complete the evaluation	Up to 6 months in local clinics; less if seeing individual practitioners
Functional Impairment	The condition must affect educational performance (such as; academics, ability to communicate effectively, work in groups and acquire the necessary social competence to be successful after high school).	The condition may or may not be impairing to be clinically diagnosed.
Results are intended for:	Developing the student's Individualized Education Program, (including identifying appropriate educational goals and objectives, acommodations, modifications, and determination of the least restrictive environment) in order to provide the student with a free and appropriate education.	Guiding parents to appropriate next steps in intervention (both in and outside of school) in order to promote overall wellness and optimal outcomes for youth with ASD and their families.

1.3 Overview of the ASD Educational Evaluation Process in Colorado

This Guideline identifies six key components to the educational evaluation process to determine a student eligible for special education services with an ASD. The components will most likely occur in a sequence of steps as represented by the diagram. As stated at the beginning of this document, this is guidance to school districts and BOCES of a thorough process but is not a requirement. Each administrative unit will determine the process that best fits their own collaborative model.



Each component has a particular goal within the educational identification process:

1. DETECT – Families, educators and/or other members of the school community notice students who are struggling to participate and learn and have some difficulty with social interactions, communication and flexibility.

2. REFER – School leaders create an efficient way for educators and families to communicate concerns about a student and begin the evaluation process.

3. SCREEN – Members of the Child Find or evaluation team gather and review information in order to determine whether or not to begin a formal evaluation process.

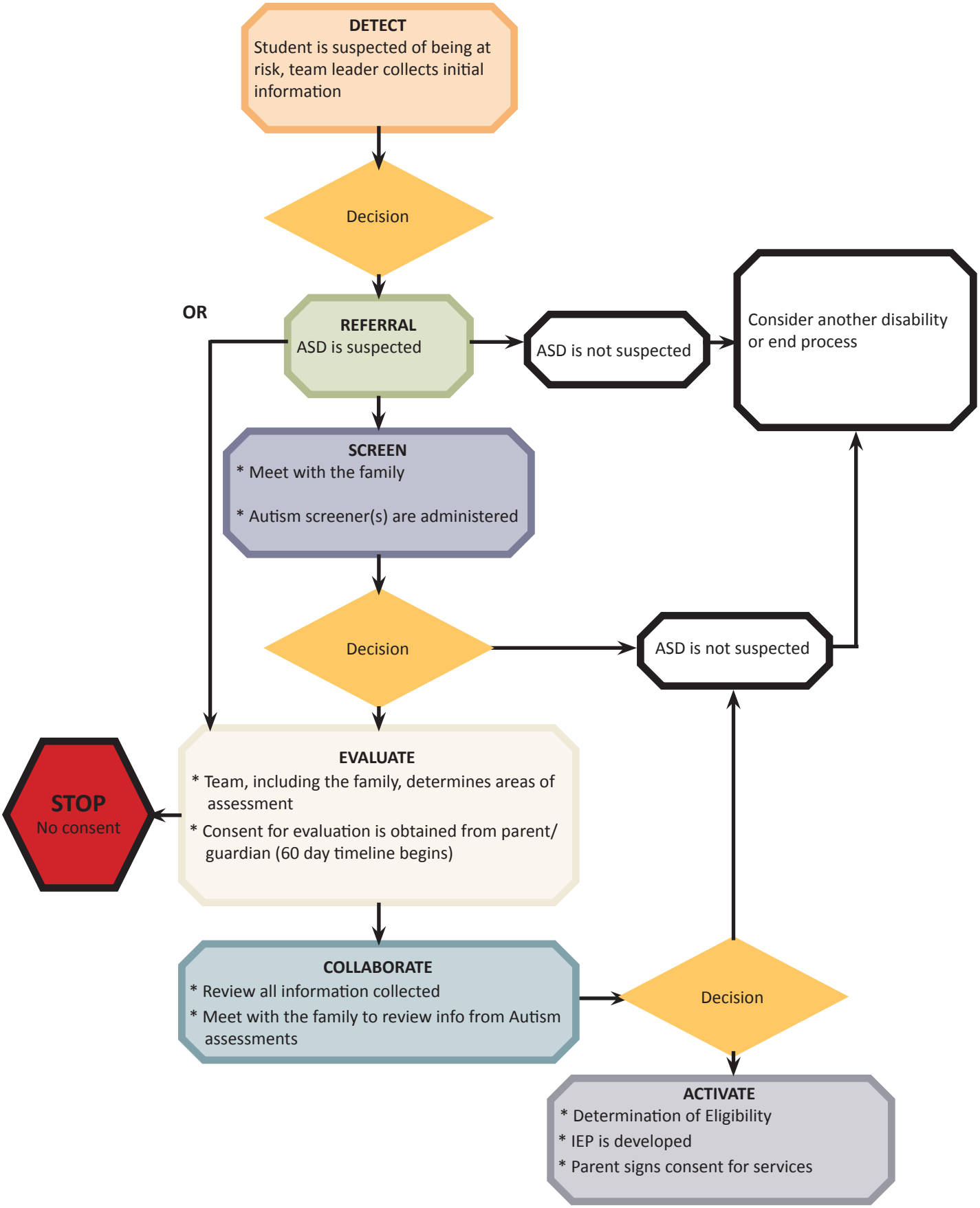
4. EVALUATE – The team will conduct a full evaluation to gather all information needed to inform the eligibility decision making process.

5. COLLABORATE – The team, including the families, share information and engage in a collaborative review of information and determination of eligibility regarding the most appropriate category for the student at this time.

6. ACTIVATE – Information gathered during the evaluation is integrated into the student's Individualized Education Program (IEP).

The components will be discussed in more detail in Section II. Following is an example of a flow chart based on the six components.

AUTISM SPECTRUM DISORDER EVALUATION FLOWCHART



Section II: Conducting an Educational Evaluation for ASD

Detect 2.1

Early detection of ASD means that families, doctors, early childhood teachers and caregivers, as well as, general educators should have general knowledge of the basic characteristics or "Red Flags" of ASD. The Center for Disease Control (CDC) has a chart of typical development and areas of concern for children two months to five years of age, which is written in both English and Spanish. Autism Speaks has information and a video glossary of young children with and without ASD. Early identification should lead to timely access of effective interventions and services. Appropriate interventions, at home for the child under three or in the classroom for the school aged child, should start as soon as a child is suspected of having ASD, (National Research Council, 2001).

Refer 2.2

Generally, referrals for an evaluation for Part C services come from family members or a pediatrician or doctor. It may be a relative, neighbor or another caregiver who sees the child regularly and talks to the family about their concerns and suggest that they seek an evaluation. The family contacts either the school district's Child Find Coordinator, since most districts evaluate the children birth to three, or their local Community Centered Board (CCB), the agency that provides Part C services, to request the evaluation.

Specific referral protocols will differ from district to district or school to school (See Section III for examples of district or BOCES referral forms). Usually, the educator who has concerns about the child's social-communication development brings those concerns to the attention of the school's problem solving team, school administrator, special education coordinator, or the Child Find Coordinator and requests an observation or consultation. Sometimes it is a family member who expresses these concerns and requests an evaluation or if the student is already receiving special education services, it may be initiated by someone on the IEP team. It is the administrative unit's responsibility to inform staff and families of their referral policies and procedures. For the child 3-5 years old and not in school, the referral may come to the Child Find Coordinator from the family, doctor or other source outside of the school district. If a child is suspected of having a disability, the Response to Intervention (RtI) process may not be used if it would possibly delay the child access to services. According to a memorandum from the federal Office of Special Education Programs (OSEP), "States and LEAs have an obligation to ensure that evaluations of children suspected of having a disability are not delayed or denied because of implementation of an RTI strategy" (Melody Musgrove, 2011) The team would do an initial evaluation to determine eligibility for special education.

As part of the referral process, a person with expertise in the characteristics of autism may want to do an initial observation and interview with the teacher. One of the challenges of observing students for behaviors associated with ASD is that the most important characteristic to look for actually requires observing an absence of behaviors or skills that other students of the same developmental level naturally display. For example, beginning in preschool and throughout their school career, we expect children to readily and consistently demonstrate appropriate social-emotional and communicative behaviors for their age. The table "School Observations Guide" in Section III has a list of behaviors that typically developing peers would be doing consistently. If the behaviors are not observed or not to the degree expected, there would be a concern of ASD. Using the information

gathered from the referral form, interview of the teacher and the observation, the team may determine there are enough indicators to warrant further assessment and a plan for the next steps can be developed. This initial process could eliminate unnecessary evaluations and worry by the family if it is decided the child does not have the features associated with ASD.

2.3

"Screening" means gathering some initial information about behaviors of concern and using that information to determine whether or not a more time intensive and thorough evaluation is needed. Many professionals view screening as a preparatory activity that is part of the process of collecting information on the child's present levels of functioning and using it as part of a body of evidence by the school problem solving team to determine interventions or next steps. It is important that the family/guardian is brought into the process as early as possible. They generally attend the problem solving team meeting but may be contacted by someone before the meeting who will share the concerns identified and ask if the family has concerns about their child as well. For more information on family involvement in the process please see the Response to Intervention (RTI) Family & Community Partnering: On the Team and At the Table" Toolkit. The family may be asked to complete an autism screening instrument. If the family or caregiver reports typical development through the first three years of life and the problems began to occur later, look at other possible causes since there are other conditions that have similar patterns of behavior such as a Serious Emotional Disability, Traumatic Brain Injury or Reactive Attachment Disorder. It is important to help families understand that a screening is less sensitive than an evaluation and will identify children at risk for ASD when a full evaluation may determine the child does not meet the criteria for an ASD. The administrative unit may prefer to have a parental consent form specific to screening. (See the Resources section for the guidelines on identifying a Serious Emotional Disability or Traumatic Brain Injury.)

When screening for very young children (birth to three years) families are an essential part of the process. In Colorado, evaluating and determining eligibility for services is a partnership between the local school district or BOCES and the Community Centered Boards (CCB). When a child is referred for an evaluation, the family may contact either the CCB or the school district Child Find Coordinator. While information is collected about the nature of the concern and "Red Flags" for ASD are present, this should be relayed to the multidisciplinary team who will conduct the screening and evaluation so they will include someone knowledgeable in identifying ASD at this early age. The American Academy of Pediatrics recommends "early and continuous surveillance and screening for ASD to ensure that children are identified and receive access to services as early as possible." When evaluating, the focus is on the absence of subtle social and communication skills, such as joint attention, pointing to relay information or turning to one's name, as opposed to the presence of overt, abnormal behaviors. Refer to the "Red Flags" chart at the beginning of this document for more characteristics by age. The National Professional Development Center on Autism Spectrum Disorders has a short training module on Early Identification of Autism Spectrum Disorders which includes videos of young children who show signs of ASD.

The screening may be done in the child's home or other location that is accessible for the family. Elements of the screening process may include:

- Interview of the caregiver with a general screener such as Ages and Stages
- Collection of ASD specific information with a screening instruments such as the M-CHAT or other screening tool appropriate for the child's age
- Observation of the child

If the screening results indicate the need for further evaluation, the multidisciplinary team conducts the evaluation. Often the screening and evaluation will take place on the same visit. For more information on the referral and screening, go to Early Intervention Colorado. The information for families is available in English and Spanish. Children birth to three who already have a diagnosis of ASD should be referred directly to the CCB to begin the Individual Family Service Plan (IFSP) process.

Sharing the Results of the Screening

Approaching the sharing of screening results as a child-focused, collaborative endeavor will likely create trust and a sense of support for the family and the child. Sharing screening results is a delicate and private interaction. Limiting the participants to the family members and one or two team members is important. Some families may experience strong emotions during this conversation and smaller forums will be sensitive to the family's needs. Many families need some time to process the information and may benefit from another conversation at a later time to address questions the family may have after the initial meeting. The next section discusses in-depth, how to share the results of the evaluation. The team may want to view the webcast Sharing Screening Results with Families from the Waisman Center at the University of Wisconsin for a presentation on what to consider when talking with the families.

If the problem solving team decides screening is not necessary or the district or BOCES policy is not to screen, then skip this step and go to "Evaluate".

Note: See Screening and Assessment Tools in Section III, for additional screening instruments for all ages and an example of a Developmental History Questionnaire.

Evaluate 2.4

Evaluate by using a variety of methods to gather information about the child in order to determine if he or she is eligible for special education services, and if so, under which eligibility category. Parent/guardian consent is required in order to conduct evaluation activities.

Federal law specifies that an educational evaluation is designed to address two questions: (1) is this a child with a disability as defined in IDEA and the Colorado regulations, and (2) does the disability adversely impact the child's ability to benefit from regular education alone? There must be a need for specially designed instruction for the student to qualify for special education services.

When determining educational impact, educational evaluations need to include the following features:

- Assess in all areas of concern, as they pertain to functioning in school for 3-21 year olds and within the context of the family for children birth to three.
- Use multiple methods of collecting information (e.g., interviews, observations, formal testing)
- Collect information from different sources (e.g., family report, teacher report, child care provider report, observation by someone with expertise in ASD).
- Administer the evaluation in the student's primary language.
- If the student is 14 or older, include guidance counselors or vocational counselors who can administer vocational/interest assessments.

IDEA specifies the participants that the Child Find or IEP team must include when a student is being considered for special education eligibility. All members, including families, must have the opportunity for meaningful participation in the decision making process. Each Child Find or IEP team must consist of the following:

- The student's parents/legal guardians
- At least one general education teacher, if the student participates in the general education environment
- A special education teacher that is providing or will provide services to the child
- A special education administrator (or designee) who has knowledge of and is authorized to commit resources
- A representative from each member of the evaluation team who can interpret the results of the assessments (e.g., school psychologist, occupational therapist, early childhood special educator, etc.)
- The student, when appropriate

At the family or district request, additional attendees may include but are not limited to:

- Additional school personnel who currently work with the student or may in the future
- Other persons the family invites, such as community practitioners, extended family members, other caregivers or advocates

It is also recommended the multidisciplinary team include at least one person with specific knowledge of autism spectrum disorder.

Types of Assessments Recommended for an Evaluation of Students with Possible ASD

During the comprehensive evaluation no one assessment method alone is sufficient to determine eligibility for autism spectrum disorder. The multidisciplinary team will gather information through a variety of assessments, observation and data collection. Which assessments and the amount of information collected will be determined on a case-by-case basis. See Screening and Assessment Tools in Section III for a list of assessments.

- Behavioral observations take place in natural settings by a person or persons with child development experience and knowledge of ASD.
- Family/caregiver report of child's developmental history (e.g., first words/phrases, first steps), medical history and current strengths and difficulties, establishing that concerns were present before the third birthday, with the exception of a very high functioning child (no language delay) (See Section III for an example Developmental History Questionnaire).
- A screening tool specific to ASD may be completed by family, teacher or both.
- Teacher input with a focus on a child's social, communication and/or play skills in natural activities and routines, and need for structure and modification to encourage child participation in learning.
- Review of existing educational records and reports regarding the child's achievement, behavior, participation in educational opportunities, with a look at whether or not social-communication difficulties accompanied by behavioral inflexibility are impacting the child's educational performance.
- Direct interaction with the child in either a play-based or semi-structured interaction with opportunities to probe the child's social-emotional understanding and observe the child's coordination of verbal and nonverbal communicative behaviors (e.g., does he easily coordinate his eyes, facial expressions, and/or gestures with his verbal communication?).
- Administration of an assessment tool specific to autism, such as the Autism Diagnostic Observation Schedule, 2nd edition or the Autism Diagnostic Inventory, or both.
- Reports by outside sources including the diagnostic report, if available, will be considered.
- Standardized assessment of cognitive functioning, adaptive skills, executive function, speech/language/communication, academic achievement, sensory profiles and motor foundation/motor planning may add valuable information but must be determined on a case-by-case situation.

Additional Elements to Consider:

There is evidence that some youth with ASD tend to show

some specific profiles across standardized assessments. Examining scores can provide important information for determining eligibility and for program planning. It is important to note that these patterns are associated with, but not always present, in ASD:

- Split between verbal and nonverbal intellectual potential (has been observed in both directions - some students with ASD show relative strengths in nonverbal IQ, while others show marked strengths in verbal IQ).
- Discrepancy between IQ and adaptive skills (several studies suggest that many youth with ASD have IQ scores that are much higher than their standard scores on adaptive behavior measures of real-life competence (such as the Vineland Adaptive Behavior Scales).
- Relative weaknesses in subtests that tap fine motor dexterity or require fast processing.
- Tendency to provide tangential, associative responses when asked to define a word; may give one specific part of the definition but lacks the full concept.

Note: See the Screening and Assessment Tools table in Section III for information on assessments that will measure behaviors that are areas of concern for a child with ASD and some that measure the features of ASD.

Using the Colorado Criteria in the Evaluation Process

The Colorado eligibility definition and criteria for Autism Spectrum Disorder is in two sections. The first, ECEA 2.08(1) - 2.08(1)(a), establishes that the student meets criteria for Autism Spectrum Disorder. For the child to be determined as a child with Autism Spectrum Disorder under ECEA Rules all boxes in this section of the Eligibility Checklist must be checked "yes." Once it is established that the child meets criteria, the second section is reviewed for additional characteristics that may impact a student's education. These characteristics may be important for program planning purposes. The Colorado IEP Determination of Eligibility for Autism Spectrum Disorder check list can be found on the Colorado Department of Education website on the IEP Forms webpage and in the Supporting Documents section. There is also a Determination of Eligibility for ASD Worksheet included in the Supporting Documents section, which can be used to guide the IEP or evaluation team through the process. The criteria can be used to determine if there is enough evidence of the characteristics of ASD and make the determination that the student is eligible for an IEP.

Summarizing the Information

In order to make a determination, all information must be brought together and summarized. The form "Summary of Results from Evaluation for ASD" in the Supporting Documents section can provide a structure to assimilate the information in one place and look for features and trends. There are certain things to look for which may aid in the determination of whether a student does or does not qualify for services under the ASD category.

- Look for consistencies, there must be evidence of social-communication problems, which are pervasive across settings and people; if the student, at times, functions as their typically developing peers, **the team may want to consider another disability category.**
- If there is a history of trauma, abuse or neglect, or in the case of foster care or adoption where there is no early history, consider other possible causes for the behaviors observed.
- Look at the student's developmental level and estimated cognitive potential; there should be a discrepancy with adaptive skills being lower than expected, if no such discrepancy exists, **think about an intellectual disability.**
- Look for the impact that the features of autism has on their educational performance.
  - Are there academic challenges, such as reading comprehension or in the area of writing?
  - Do the social/emotional challenges interfere with working in small groups, participating in classroom activities or making healthy relationships?
  - Are rigid patterns of thinking and/or behavior affecting learning or the school environment

If the data indicate features of ASD in the three areas as listed that are listed in the eligibility criteria, and there is educational impact to the degree specialized instruction is needed, then the student qualifies for special education services with the educational determination of Autism Spectrum Disorder.

The evaluation for children who will receive Part C services will consist of a multidisciplinary team of at least two professionals. If during the initial screening or phone conversation there are "Red Flags" that alert the coordinator that this may be a child at risk for ASD, parental consent for an evaluation shall be obtained and then one of the chosen team members should have expertise on the characteristics of ASD in a young child. The National Professional Development Center on Autism Spectrum Disorders has a training module on Early Identification of ASD. During the play-based assessment, a team member may interview the family using a screening instrument, normed for the age of the child, while other members interact with the child, observing for

features of ASD. The team will then determine eligibility for services and the information is shared with the Part C Service Coordinator. The team may choose to discuss with the parents the characteristics of ASD observed at the end of the evaluation or they may choose to have the Coordinator and service providers share this information with the family during the Individualized Family Service Plan (IFSP) development. See the Sharing Screening Results with Families webcast from the Waisman Center at the University of Wisconsin.

2.5

Involving the family throughout the educational identification process is very important. IDEA states that parents are to have "meaningful participation" and are part of the multidisciplinary team. There are many different ways to share information with families about assessment results.

The most important aspect of this communication is that it be an authentic interaction with time for questions and discussion. The tone should not be one of an "expert imparting definitive news." Rather, this is a conversation that begins an ongoing collaboration between the family and the school with the shared mission of providing appropriate educational programming and supports for the child.

There may be instances where the child presents differently at school than at home, leading to school personnel and family members experiencing different behaviors from the child. Respecting these differences is important for establishing and maintaining effective home-school collaborations. As with sharing the screening results, sharing the information from the evaluation should take place before the IEP meeting with the family and should be done by one or two team members who have established rapport with the family.

Positive Examples

- Listen to families concerns using reflective listening.
- Know the names of the families and child, especially if the child has a commonly used nickname.
- Explain the process up front, check for understanding.
- Lead all conversations about the child with something positive.
- Use factual language about behavior, focus on what child is doing (i.e., hitting, crying, poking, or leaving the class during writing assignments).
- Establish a consistent schedule for communication, including mode (i.e., email, phone, daily log).
- Try to bring the family through the process with you, explaining the steps of the evaluation and what an educational identification will mean.
- If possible, give families results of assessments as they come in with some explanation, so that at the feedback meeting they are not seeing them for the first time. Explain why the results as a whole add up to ASD or not ASD at the meeting.
- Set up a meeting to discuss the results of the evaluation but keep it as small as possible; it could be very stressful for families. Limit the number of school representatives.
- If ASD, explain the importance of follow up with medical diagnostic evaluation due to implications of access to private therapies and insurance coverage.
- Help families if they become emotional, have tissues, offer a 5-minute break, tell them it's ok if they need a few minutes to regroup. You could call the break for other reasons if the family member is appears to need one but is reluctant to stop the meeting on their behalf. Acknowledge emotion; let them know it is normal.
- Make families a true member of the team in decision making. Respect family's expertise of their own child while retaining expertise on children in the educational setting.
- If ASD, help families understand the next steps, why this identification matters for programming.

Negative Examples

- Barrage the family with language/acronyms about assessments or district process without any explanation.
- Not responding to emails or phone calls.
- Using judgmental language about behaviors (i.e., refuses to cooperate, mean to peers, annoying others, causing problems, aggressive, doesn't care about work, mean, non-compliant).
- Overwhelming families with assessment results, using technical language without checking for understanding.
- Not knowing child's history.
- Using district or legal language when the family is trying to connect or is distressed.
- Telling the family you need to leave an IEP meeting before it is over, or before you have contributed your report.
- Not being present at the IEP meeting if you are a critical team member.
- Not responding when a family member is emotional.
- Continuing to report your findings when the family member is overcome with emotion.
- Leading off feedback session with child's challenging behaviors.
- Not treating family like a part of the decision making team. Telling them what is going to happen without discussion about what should happen.
- Giving an educational determination of ASD without helping the family understand why this is important for programming.
- Announcing drastic programming changes in a meeting or in passing conversation, without explaining how you came to that recommendation.
- Straining collaborative relationship by putting district rules ahead of conversation about what is best for their child.

Tips for Communicating with the Family

- Understanding an identification of ASD elicits a variety of emotions; from confirmation and relief to anger and denial. The rapport that has been built during the evaluation process can aid the team in assessing how to better help the family and provide them with support. Know what medical and community resources are available in your area and provide the information to the family.
- Explain the difference between eligibility for services with ASD in the school setting and a medical diagnosis of ASD. If parents decide to pursue a diagnosis to be eligible for services and therapies outside of school, have a list of the resources and be ready to help them get started. Many communities in Colorado are not near medical centers where the child can receive a diagnosis. Reports written for the IEP from the comprehensive evaluation that gives detailed information on the assessments and characteristics of ASD observed may be used by a local family physician or pediatrician to be able to make a diagnosis.

The multidisciplinary team, which includes the family, makes the determination at the IEP/IFSP meeting whether or not the child is eligible for services and if there is enough evidence to meet the criteria for Autism Spectrum Disorder. Once they have agreed on an eligibility determination, the team writes a written summary of the process that they undertook, the decisions they made, and why. Each team or AU will determine the process that is most effective for their members.

The eligibility determination will be reviewed at least every three years or earlier if needed. As the student responds to instruction and/or matures, the IEP team may determine, based on the data, that the student no longer meets criteria for special education services or that the student's disability is more accurately described by another disability category.

Activate **2.6**

The final component of the evaluation process involves gathering all data and information collected to use in the development of the Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). The result of a thorough and thoughtful evaluation is to develop an appropriate program that will allow a child to make significant gains. In developing the IEP, all areas that were found to be challenges to success at home or school should be addressed. For a child with ASD, this will include social, emotional, language and behaviors as well as academic areas. The team member with knowledge of the effect that ASD has on the student's performance is an integral participant in the development of the educational program.

- Have information on autism spectrum disorder to give during the conversation. There are many websites listed in the resource sections that may be useful and family friendly.
- Explain clearly the role of each team member as well as the IEP process from the evaluation to implementation of the program. Parents need to understand their role and the importance of family and school working together to maximize their child's progress. It would be very beneficial to have this information in writing as parents can become overwhelmed with this new information and may not hear or retain everything being said. If there are private providers involved, they also should be included in the discussion so everyone is working together for the benefit of the child.

The following are examples of what families would like the team to know regarding what to do or not do when engaging with the family. These were written by a parent based on her experiences and the experiences of other parents.

2.7 Case Study – Jay

This is an example of how the referral and evaluation process could be implemented in an elementary school with a family of a child without a diagnosis and where ASD had never been discussed.

DETECT – Mrs. Green, the teacher of a 3rd grader named Jay, has concerns that he is not keeping up with his peers academically or socially. He generally plays by himself at recess. When he tries to play with his peers, he has difficulty keeping up with their pretend play, which often ends with arguing and hurt feelings. She sees other differences in Jay that, from her years of experience as an elementary school teacher, she feels are not "typical." The school has had some people present on autism spectrum disorder and she has seen programs on TV and read about ASD in the news. She feels she may be seeing some of the characteristics in Jay and so she discusses her concerns with the principal.

REFER - The coordinator of the Autism/Behavior Team, Mr. Martin, is contacted by the principal requesting an observation of Jay by someone on their team. He describes concerns about Jay who has been doing okay since kindergarten, but is now really having significant challenges keeping up academically. The principal reports:

"He seems to be a bright child, perhaps a little naïve or less mature than some of the other boys in his class, but work should come fairly easy for him. He did very well in 1st grade, but he's not keeping up now. He's not a very happy little guy either, he looks like he's on "high alert" most of the time I see him, and he doesn't smile often. I don't think he has any friends, I see him alone at recess and at lunch. Apparently this year his achievement scores are low and his reading comprehension is beginning to drop below grade level. Interventions the teacher has implemented have not led to any improvement. We are suspecting autism spectrum disorder because he seems to have a lot of the characteristics. We would like you to come and take a look and tell us what you think."

The coordinator sends Mrs. Green an ASD Referral Information Form and asks her to complete it and send it back to him. Upon reviewing the form and doing a short interview with Mrs. Green over the phone, he determines there are enough indicators of ASD to send a team member/specialist to do an initial brief observation. The team member, Ms. Jones, schedules a 1-hour visit to Jay's school. She begins by observing Jay in his 3rd grade class during a small group literacy activity, followed by recess, bathroom break, and independent writing time. During these activities, she is watching for:

- how Jay participates in the school activities
- how aware he seems of others
- how interested he is in others
- how flexible he is
- how well he communicates with others
- activities that seem particularly challenging, as well as those that seem to come more easily
- where his attention is (Does he appear to be listening to the teacher or "in his own world"?)
- how he starts his work - without reminders or needs to be prompted
- how he handles corrective feedback
- his level of involvement with other children during recess (Is he an active part of play with others? Is he more of an onlooker? Is he playing near but not with the others?)

When the opportunity allows, she speaks briefly with Mrs. Green and her teaching assistant about how Jay is doing. Mrs. Green says, *"He's a smart little guy. He seems capable, but he doesn't seem to be able to show what he knows consistently. It is like he has it today but it's gone tomorrow. It's a puzzle because he works hard and assessments show he has the ability, yet he struggles. Also, he doesn't seem to have any friends. The kids like him, he's very likable, most of the time, but he has a hard time compromising which makes it hard for them to want to be with him for very long. He really is a good kid and the others sense that. They give him some slack. His biggest problem this year is reading comprehension. He's giving me answers about stories he's reading that relates to the story but is not what I'm asking. He loves to read and is one of my best readers, but he's either not paying attention or not understanding what's actually happening in the story."*

The teaching assistant reports that, *"Independent writing is a nightmare, for him and for us. He really seems to dislike it and just sits there and scowls. He will not put pencil to paper. When I get him started, he can gain some momentum and occasionally has done some nice work; it isn't a lot, but can get something done some days. We started sending his unfinished work home, but recently his mom has been saying that it's been too difficult at nights now, trying to get the work back out. Even she's having trouble getting Jay to print out a sentence. If you ask him to tell you about dolphins and flightless birds, and you'll see how much Jay can understand. He also knows a lot about the zoo and really likes talking about it. We've been trying to read books on animals and write about them and that helps some."*

Red Flags Observed

- Inconsistent learning style
- Ability doesn't match output
- No friends
- Difficulty compromising
- Reading comprehension
- "Wh" Questions
- Starting a difficult task (writing)
- Knowledgeable in area of interest
- Excessive talking about area of interest

Ms. Jones briefly relays to Mrs. Green the strengths and challenges she has noted. The team meets and reviews all data collected, which now includes present levels of functioning academically, socially and emotionally, in the school environment. The data indicates the possibility that Jay may have ASD and they decide to proceed with an evaluation. They give the information to Mrs. Green and the school IEP team. Ms. Jones becomes a member of the school special education team who will be conducting most of the evaluation.

SCREEN - Mrs. Green, who has had frequent conversations with Jay's mother, Mrs. Adams, regarding their concerns over his difficulties at school this year, contacts her and sets up a time to talk. The two meet one day after school and Mrs. Green begins the conversation asking Mrs. Adams how things are going at home and what concerns she has for Jay. She then tells Mrs. Adams, "I'm thinking we should do some formal assessments to find out what is causing these difficulties. From what I am hearing from you and we are seeing at school, I am thinking there are two possibilities we should investigate further, with your permission. First, it's possible that Jay has a learning disability or a specific difficulty in something, like writing or reading. There are some signs of a possible problem understanding language that we should ask a speech-language pathologist to assess. Another possibility is that Jay may be showing signs of autism spectrum disorder. Has anyone ever mentioned autism spectrum disorder to you before? Is that a familiar term?"

Mrs. Adams says, "Kind of…I'm not exactly sure. You mean, like Rainman? Jay's not like Rainman." Mrs. Green replies, "Well, not exactly like Rainman, autism spectrum disorder or ASD is a developmental disability that involves social and communication skills in particular. Often, people with ASD have difficulty adjusting to changes in their routines or learning to play and talk about more than just a few topics. People with ASD can vary a lot from each other, some are average or above average and others have intellectual disabilities; some are socially interested but don't know how to be a flexible, spontaneous friend and have a back-and-forth conversation, others are less interested in people and prefer to play with objects. In general, ASD is about differences in social interaction, communication and how flexible or open to change a person is. It is called a "spectrum" because there are so many ways people can have this general pattern in common, but also present very differently from each other." Mrs. Adams is given the Social Responsiveness Scale (SRS), a screening tool, to take home and fill out with her husband. When the SRS is completed and sent back to school, the team sets a date with the family to get together and review all the information collected so far. At this meeting it is determined that Jay presents with enough features of ASD to warrant a full evaluation. The team, including the parents, decides what information, assessments and observations would be needed to address Jay's learning challenges along with assessment for ASD.

EVALUATE – Mr. and Mrs. Adams is given a Prior Written Notice listing the formal and informal assessments and observations the team plans to use and is shown where to sign giving consent to evaluate. Jay's parents decide to proceed with the evaluation and ask for a little more information on autism spectrum disorder. Along with assessments for reading, writing and pragmatic language, a BRIEF will be done to check executive functioning skills and the ADOS will be administered to check for characteristics of ASD. Jay's hand writing and fine motor skills will be assessed due to his difficulty with written assignments and a sensory profile completed to check for sensory differences.

COLLABORATE – Mrs. Green convened a meeting with Jay's parents and the autism consultant to review the results of the evaluation. Since the results indicated Jay had many characteristics consistent with autism spectrum disorder, the team wanted to share this information before the IEP meeting in a small setting where parents could focus on just this information and ask questions. This also will allow them to freely stop or pause the meeting if they need a break while processing what is being discussed. Mrs. Green begins by referencing a few behaviors the parents identified as being of concern to them that were also concerns at school. "It seems as though you are noticing that Jay tends to withdraw from social situations, seems confused by some of the behaviors of other kids, and has a difficult time having a conversation or talking about his day and we are seeing those things too. It also sounds like you are concerned about his limited range of interests and you've identified that it is difficult to get him to do other things than play video games. These kinds of challenges, along with some difficulties he has organizing himself to get his assignments done and turned in, can be consistent with an autism spectrum disorder. We will be discussing these results along with the results of the other assessments at the IEP meeting and then we, as a team, will determine if Jay needs special education services and if he does, would he meet the criteria for ASD or would another category be a better fit for him? Do you have any questions for us?" The autism consultant explains that qualifying him with ASD for special education was not the same as a diagnosis and shows them a chart listing the differences between them. When all of Mr. and Mrs. Adams questions were answered the date for the IEP meeting was confirmed.

Section III: Supporting Documents

The following documents are examples for your information only. They may aid in the evaluation but are not required.

References and Resources
Example Forms
- Autism and Behavior Consultation Team Referral Form
- ASD Referral Information Form

Developmental History Questionnaire
Screening and Assessment Tools
- Developmental/Intellectual Screening Tools
- Communication, Speech and Language Assessment Tools
- Nonverbal or Difficult to Engage Student Assessment Tools
- Associated Features Measures

School Observation Guide
Summary of Results from Evaluation for ASD
Determination of Eligibility Worksheet
Determination of Eligibility: AUTISM SPECTRUM DISORDER

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National Research Council (2001) Education Children with Autism. Committee on Educational Interventions for Children with Autism. Catherine Lord and James P. McGee, eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

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Eikeseth, S., Smith, T., Jahr, Erik, Eldevik, S. (2007) Outcome of Children with Autism Who Began Intensive Behavioral Treatment Between Ages 4 and 7. Behavior Modification, 31(3), 364-278.

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Musgrove, Melody, (2011) Memorandum: a Response to Intervention (RTI) Process Cannot Be Used to Delay-Deny an Evaluation for Eligibility under the Individuals with Disabilities Education Act (IDEA). Washington, DC.

Minshew, N. J., & Williams, D. L. (2007). The New Neurobiology of Autism: Cortex Connectivity, and Neuronal Organization. Archives of Neurology, 64(7), 945-950.

Osonoff, S., Heung, K., Byrd, R., Hanson, R., & Hertz-Picciotto, I. (2008) The Onset of Autism: Patterns of Symptom Emergence in the first Years of Life. Autism Research, 1(6), 320-328.

Howlin, P. (2008). Autism and diagnostic substitution. Developmental Medicine & Child Neurology, 50: 325. Dol: 10.1111/j.1469-8749.2008.00325.x

Rogers, S. J. & Vismara, L. A. (2008). Evidence-Based Comprehensive Treatments for Early Autism. Journal of Clinical Child and Adolescent Psychology, 37(1), 8-38.

Rogers, S. J., Young, G. S., Cook, J., Giolzetti, A. & Ozonoff, S. (2010) Imitation actions on objects in early-onset and regressive autism: Effects and implications of task characteristics on performance. Developmental Psychopathology, 22(1), 71-85.

Resources

American Academy of Pediatrics:
http://www.aap.org/en-us/Pages/Default.aspx

Association of University Centers for Disabilities: (AUCD). which serves as a hub for technical assistance, service, treatment and research in developmental disabilities.
http://www.aucd.org

In Colorado, the University Center for Disabilities is the JFK Partners program: http://www.jfkpartners.org

Autism Speaks
http://www.autismspeaks.org

Autism Society of America
http://www.autism-society.org/

Centers for Disease Control Autism Awareness Campaign: "Learn the Signs. Act Early":
http://www.cdc.gov/actearly 1-800-CDC-INFO

For video clips of children with and without ASD at different ages and developmental levels, see:
http://www.firstsigns.org/asd_video_glossary/asdvg_about.htm

For handouts for parents and colleagues about autism (fact sheets, developmental milestones, etc.), see:
http://www.cdc.gov/ncbddd/autism/freematerials.html

CDE guidelines on determining eligibility with a Serious Emotional Disability:
http://www.cde.state.co.us/cdesped/sd-emotional

CDE guidelines on the educational determination of a Traumatic Brain Injury:
http://www.cde.state.co.us/cdesped/SD-TBI.asp

CDE guidelines on the educational evaluation of Autism Spectrum Disorder
http://www.cde.state.co.us/cdesped/sd-autism

For the part of IDEA that describes the legal requirements for an evaluation for educational eligibility:
http://idea.ed.gov/explore/view/p/%2Croot%2Cregs%2C300%2CD%2C300%252E304%2C

For a list of eligibility categories and their definitions:
http://idea.ed.gov/explore/view/p/%2Croot%2Cregs%2C300%2CA%2C300%252E8%2C

For an assessment toolkit development by the Office of Special Education Programs (OSEP):
http://osepideasthatwork.org/toolkit/tk_descision.asp

To learn more about Evaluation Practice Parameters Developed for Medical/Clinical Settings, see:

American Academy of Pediatrics Toolkit for Evaluating Children for Autism:
https://www.nfaap.org/netFORUM/eWeb/DynamicPage.aspx?webcode=aapbks_productdetail&key=d830e6db-10a1-49f0-8ef1-83a84284de8f

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revisions). Washington: American Psychiatric Association.

Filipek, P.A.; Accardo, P.J.; Ashwal, S. et al. (2000). Practice Parameter: Screening and diagnosis of autism: Report of the Quality Standards Subcommittee of the American Academy of Neurology and the Child Neurology Society. Available online: http://www.neurology.org/content/55/4/468.full.html

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Ozonoff, S.; Goodlin-Jones, B.L., & Solomon, M. (2005). Evidence-based assessment of autism spectrum disorders in children and adolescents. Journal of Clinical Child and Adolescent Psychology, 34(3), 523-540.
World Health Organization. (1993). The ICD-10 classification of mental and behavioural disorders: Diagnostic criteria for research. Geneva: World Health Organization.

For pediatrician guidance on screening for developmental conditions, see:
http://www.developmentalscreening.org/

For Parents:
Peak Parent Center – a support for educating a child with a disability, offers trainings and resources
http://www.peakparent.org/

The Arc has regional offices that support families through education of family/child rights and responsibilities, support groups, trainings, advocacy and resources. This link has information on each regional Arc.
http://www.thearcofco.org

Autism Society of Colorado – provider referral, events, support groups, etc.
http://www.autismcolorado.org/

Parents Encouraging Parents (PEP) - the Colorado Department of Education provides three free conferences a year for parents and professionals
http://www.cde.state.co.us/cdesped/pep

Family Voices – support for families with children with disabilities, resource for insurance questions regarding coverage for intervention outside of school
http://www.familyvoices.org

Information in other languages:
For materials about ASD in Spanish, see:
http://www.cdc.gov/ncbddd/autism/index.html the right menu column has an option, "View page in: (Spanish)
http://www.parentcenterhub.org/resources/
http://www.autismspeaks.org/family-services/non-english-resources/spanish

The Iowa Regional Autism Services Program has information on autism for families in Arabic, Bosnian, Laotian, Spanish and Vietnamese, http://www.chsciowa.org/regional-autism-services-program.asp

Autism and Behavior Consultation Team
Referral Form

Referral Date: _____ Student:_____

Date of Birth: _____ School:_____

Age: _____ Grade: _____ Teacher:_____

Parents Name(s): _____

Phone: _____

Email: _____

Does the student have an IEP? ____YES ____NO

A 504 Plan? ____YES ____NO

If YES please indicate:

Disability:_____

Case Manager: _____ Email: _____

Related Services: (Speech, OT, PT, Vision, Hearing, para-support, social skills)

_____

_____

List the student's strengths and interests:

_____

_____

List the student's needs and challenges during their school day:

_____

_____

Reason for Referral (Check all that apply)

Social Concerns:

- ☐ Poor eye gaze/contact
- ☐ Poor use/understanding of facial expressions
- ☐ Poor use/understanding of gestures
- ☐ Poor body posture
- ☐ Little or no peer interaction
- ☐ Little of no spontaneous sharing of enjoyment, interests or achievements
- ☐ Lack of social reciprocity

Communication Concerns:

- ☐ Delay or lack of spoken language
- ☐ Doesn't initiate or sustain conversation
- ☐ Limited comments/responses to other's thoughts and interests
- ☐ Exhibits stereotypical/repetitive language & idiosyncratic language
- ☐ Lack of varied, spontaneous pretend play (relative to age/developmental level)
- ☐ Lack of social imitative play (relative to age/developmental level)

Behavioral Concerns:

- ☐ Abnormal preoccupation with items, topics, or ideas
- ☐ Inflexible, nonfunctional routines or rituals
- ☐ Repetitive motor mannerisms (e.g. hand flapping, finger play, etc)
- ☐ Persistent preoccupation with parts of objects
- ☐ Aggressive behavior
- ☐ Prolonged temper tantrums

Is the student's speech understandable to others?_____

How does the student express his/her wants and needs?_____

How well does the student understand language and following directions?

_____

_____

Describe how the child participates with peers:

_____

_____

Other Comments/Concerns:

_____

_____

_____

Describe interventions and/or strategies already implemented related to the areas of concern:

_____

_____

_____

Do you have any concerns about the child's behavior? If so, please describe.

_____

_____

List any pertinent information the team should know about the student and their family:

_____

_____

Please fax this form to _____ office: fax number _____

ASD Referral Information Form

Student's Name _____ Age _____

School _____ Grade _____

List people and their positions contributing information _____

_____

I. CONCERNS
Who initiated the referral and what is their relationship with the student?

_____

List all concerns:

_____

_____

How long have they been concerns?

_____

Does the family share these concerns?

_____

II. POTENTIAL IMPACT
How much are these issues currently getting in the way of a student's educational performance on a day-to-day basis? Attach the data.

	Not at all interfering	Somewhat interfering	Very interfering
Student's learning			
Learning of others			
Student's ability to independently function within school setting.			
Student's ability to handle frustration			
Student's ability to adapt to changing circumstances; make transitions			
Student's safely			
Safety of others			
Student's ability to work cooperatively with peers			
Student's ability to participate in different learning situations (e.g., small/large group)			
Other:			

Describe concerns about safely in more detail. If this is an urgent situation describe the plan in place to address these behaviors.

_____

_____

III. BACKGROUND

Does the student have a current 504? _____ IEP? _____

If so, what is his/her current eligibility determination?

_____

Describe the student's current and past educational settings and experiences:

_____

_____

Does the student have a history of any significant medical conditions?

_____

_____

To you knowledge, have there been any significant changes in the student's live – any major transitions or traumatic events in the past few years?

_____

_____

Who are the family members that communicate with the school?

_____

_____

How has the family and school been partnering?

_____

_____

_____

IV. FOLLOW-UP COMMUNICATION

What's been discussed about the educational identification process within the school team?

_____

_____

What's been discussed about the educational identification process so far with the family?

_____

_____

Has a parent/legal guardian given written permission to evaluate?

_____

_____

CONTACT INFORMATION

Contact information for family member?

Name: _____

Phone number/email: _____

Contact information for the school Lead?

Name: _____

Phone number/email: _____

If the student is in special education, who is the case manager?

Name: _____

Phone number/email: _____

Who else at the school is involved and should be included in correspondence?

Name: _____

Phone number/email: _____

NEXT STEPS:

_____

_____

_____

_____

Developmental History Questionnaire

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age _____

School: _____ Grade: _____

Parents/Guardian Name(s):_____

Person completing questionnaire: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Dear Family:

We believe families and schools are partners in their child's education. By filling out this questionnaire you can help us better understand your child's history, special health needs, and developmental progress.

- You have the right to leave any question blank.
- This information shall be considered confidential and shall not be forwarded outside the school district without the written consent of the family or guardian.
- We will use this information in addition to other assessment material in planning, with you, an appropriate educational programming or services for your child.

If you have any questions please contact one of the following individuals:

Child Find Coordinator _____ Phone #_____ Email_____
Ages 0-3

Case Manager _____ Phone #_____ Email_____
Ages 3-21

I. FAMILY HISTORY

Father/Step-Father/Guardian's Name: _____

Occupation: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Mother/Step-Mother/Guardian's Name: _____

Occupation: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

If applicable, Guardian's Name: _____

Occupation: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Language(s) spoken in the home: _____

Child's primary language: _____

Current family status:

_____Married _____Separated _____Divorced _____Widowed _____Never Married _____Blended family

Please list all People in child's immediate home and their relationship to child: _____

_____

Does child have any siblings? ____Yes ____ No How many?_____ Ages:_____

Child resides with (please include all adults living in the home):_____

_____

Any concerns about the development of siblings? _____

_____

Has any biological family member had any of the following?	Please list the biological family member's relationship to the child.
Learning Disabilities	
Speech or Language Problems	
Tourette's Syndrome	
Attention Deficit Disorder	
Emotional Problems (anxiety, depression, etc.)	
Developmental Disorder (Autism Spectrum Disorder, Asperger Syndrome, etc.)	
Diabetes	
Developmental Delay or Cognitive Disability	

Does anyone else care for your child on a regular basis? ___Yes ___No

If yes, please describe the care giving arrangements (i.e.: private daycare, family, public daycare

II. PREGNACY AND BIRTH HISTORY

Describe any difficulties during pregnancy (i.e. high blood pressure, toxemia, diabetes and/or premature contractions): _____

_____

List any prescribed and/or over the counter drugs used during pregnancy:_____

_____

Did you smoke during pregnancy? ____Yes ____No Did you use alcohol or drugs during pregnancy? ____Yes ____No
Were there any unusual or stressful situations during your pregnancy (divorce, death, illness, accident)? ___ Yes ___ No
If yes, please describe: _____
_____
Length of pregnancy (weeks):_____ Infant birth weight:_____
Were there any complications during labor and/or delivery (i.e.: difficulty breathing, cord wrapped around the neck)? ___Yes ___No
If yes, please explain: -_____
_____
Did your newborn require any specialized treatments (i.e., oxygen, IV medication)?
_____
_____

III. INFANT/TODDLER DEVELOPMENT

Rolled over by what age? _____
Sit alone by what age? _____
Crawl by what age? _____
Walk alone by what age? _____
Babbled by what age? _____
Said "mama" "dada" with meaning by what age? _____
Said other single words by what age? _____
Put two words together by what age? _____
Used longer phrases and sentences by what age? _____
Were there any losses of skills at any time? ____Yes ____No If yes, please describe:_____
_____
Did your child experience any health problems during infancy? If so what type?_____
_____
Describe your current concerns about your child's development: _____
_____
_____

HEALTH HISTORY

Date of last physical exam:_____
Family and/or physician's concerns:_____
_____
_____

Has your child had any of the following? Check all that apply.	Describe the condition and the age of onset.
Frequent ear infections	
Seizures	
Hearing Loss/hearing aids	
Vision Problems	
Head Injury	
Neglect/Abuse	
Allergies	
Sleeping Problems	
Limited diet/food sensitivities	

Has your child been diagnosed by a health professional with any disability? If yes, please describe and list diagnosing doctor:
_____
_____

Is your child currently taking any medications? ____ Yes ____ No
If yes, please list:_____

Does your child require any special medical care or procedures at home or school? ____ Yes ____ No
If yes, please explain (i.e.: G-Tube, nebulizer treatment, catheterization, tracheostomy care, oxygen, Epi-pen) _____
_____
_____

SOCIAL AND PLAY SURVEY	RARELY	SOMETIMES	FREQUENTLY
At home my child usually follows our rules and requests.			
My child enjoys physical activity such as swinging, climbing, jumping and hanging upside-down.			
My child can play independently for short periods of time.			
My child avoids messy activities such as play-dough and finger-paints.			
My child is overly alert or disturbed by minor noise and/or movement.			
My child has difficulty with hitting, kicking, or biting other children.			
My child can play cooperatively alongside other children for short periods of time.			
My child usually maintains eye contact when speaking to a familiar person.			
My child is beginning to understand sharing and turn-taking.			
My child is appropriately cautious with strangers.			
My child does not usually scream, cry, or tantrum for longer than ten minutes at a time.			
My child will sit and look at books independently.			
My child can follow simple directions (i.e.: “Go to your room and get your shoes”).			
My child points to objects (points to juice, points to a toy he/she wants).			
My child is beginning to use pretend play (cooking, going to work, talking on the phone, cleaning).			
My child has unusual interests			
My child transitions easily from one activity to another			
My child enjoys making family members laugh (makes silly faces or noises).			

What kind of games and activities (i.e.: books, dolls, blocks, art activities, balls, puzzles) does your child enjoy? _____
_____
_____

What are your child's strengths? _____
_____
_____

Any particular or unusual habits that you are concerned about (i.e.: aggression towards others, head banging, poor impulsive control, or harming themselves in anyway)? ___Yes ___No
If yes, please describe the areas of concern: _____
_____

Does the child have any out of the ordinary fears? ___Yes ___No
If yes, please describe the type of fear: _____
_____

Are there any traumatic or significant events in your child's history that you would like to share?
_____
_____

Has any other professional completed an evaluation on your child (pediatrician, speech and language evaluation)? ___Yes ___No

If yes, would you be willing to share their reports and/or findings with this evaluation team?
___Yes ___No

List all past/current treatment intervention (speech-language, psychology, occupational therapy, physical therapy, etc).
_____
_____
_____

In the event further evaluation is recommended, are there other people we should consult with who could provide additional information (such as grandparents, daycare providers, etc.)? ___Yes ___No
If yes, please name and give contact information: _____
_____

Thank You! We look forward to working with your family.

Screening and Assessments Tools

DEVELOPMENTAL/INTELLECTUAL ASSESSMENT TOOLS (Sequenced Developmentally)		
The Ages and Stages Questionnaire (Bricker & Squires, 1995)	Standardized screener for developmental concerns in children from 4 to 60 months of age. Nineteen different questionnaires cover designated age intervals. Each questionnaire covers fine motor, gross motor, problem solving, communication, and personal social areas of development. Each sub-section is scored on a pass/fail basis. Pediatric practices use this tool to learn about general development.	Bricker, D., Squires, J. (1995). Ages and Stages Questionnaire: A parent-completed child monitoring system (2nd ed.) Baltimore, MD: Brookes.
The Mullen Scales of Early Learning (MSEL) (Mullen, 1995)	The MSEL is a standardized, comprehensive measure of development for infants and preschool children from birth to 68 months. It includes five subscales: visual reception (i.e., solving problems without language), gross and fine motor, receptive and expressive language. The MSEL can be administered in a playful fashion. Items can be administered in any order, allowing for the examiner to adjust to the interests and motivation of the child being tested. The MSEL provides estimates of verbal and nonverbal problem-solving abilities. It is widely used in studies of young children with developmental disabilities. The MSEL demonstrates strong concurrent validity with other well-known developmental tests of motor, language, and cognitive development.	Mullen, E. M. (1995). Mullen scales of early learning (AGS ed.). Los Angeles: Western Psychological.
Bayley Scales of Infant Development –II and III (Bayley, 1993; 2005)	The Bayley is a standardized developmental assessment for young children (1-42 months) that requires approximately 45-60 minutes to administer. The Bayley provides a Mental Development Index (MDI) and a Psychomotor Development Index (PDI). The direct assessment also includes additional checklists for parents to complete. Psychometric characteristics are strong and the materials are child-friendly. Administration requires training for fluent, standardized use. Perhaps more appealing to young children than the MSEL (in my opinion), it can be harder to tease apart verbal and nonverbal problem solving on the Bayley than on the MSEL.	Bayley, N. (1993). The Bayley scales of infant development (2nd ed.). San Antonio, TX: Harcourt Brace.
Differential Abilities Scale, Second Edition (DAS-II) (Eliot, 2007)	The DAS is a standardized test of intelligence with versions suitable for children from ages 2 ½ to 18 years that provides age equivalents and standard scores. The DAS can be administered to children who are not verbal and it is expected that most children will obtain basal scores on the DAS – if not on the school-age version, then on the preschool version. The School-Age Version is comprised of six core subtests which yield summary scores for: verbal performance, nonverbal performance, and spatial performance, as well as an overall score termed the General Conceptual Ability (GCA). While subtests provide T scores (M = 50, SD = 10), the verbal, nonverbal, spatial, and GCA scores are reported as standard scores, with a mean of 100 and standard deviation of 15. Verbal performance and Nonverbal performance are usually used to reflect a child's profile of cognitive functioning. In terms of its psychometrics, the DAS manual reports good to excellent properties in terms of both validity and reliability and shows acceptable convergent reliability with both the WISC-IV and WPPSI-III.	Eliot, 1990. Manual for the Differential Ability Scales. Austin, TX: Psychological Corporation.

DEVELOPMENTAL/INTELLECTUAL ASSESSMENT TOOLS (Sequenced Developmentally)		
Wechsler Preschool and Primary Scale of Intelligence- Fourth Edition (WPPSI-IV) (Wechsler, 2012)	The WPPSI-R is a standardized assessment of intellectual potential designed for children ages 3 – 7 years. It contains 12 subtests, which load on either a Verbal Composite or a Performance Composite. It also provides a Full IQ estimate.	Wechsler, D. / Psychological Corporation (2012.) Manual for the Wechsler Preschool and Primary Scale of Intelligence- Fourth Edition, Austin, TX: Harcourt.
Wechsler Intelligence Scales for Children-IV (WISC-IV) (Wechsler, 2003)	The WISC-IV is a standardized test of intelligence for children ages 6-16. It examines both verbal and nonverbal intelligence performance and provides age equivalents and standard scores for each. The WISC-IV generally demonstrates good psychometric properties and shows acceptable convergent reliability with both the WASI and DAS (Wechsler, 2003).	Wechsler, D./ Psychological Corporation (2003). Manual for the Wechsler Intelligence Scales for Children. Austin, TX: Harcourt.
Wechsler Abbreviated Scales of Intelligence (WASI) (Wechsler, 2002)	This IQ screener provides an estimate of the child's verbal and nonverbal abilities in a relatively brief period of time. The WASI contains four subtests (Vocabulary, Similarities, Block Design, and Matrices), takes approximately 30 minutes to administer, and is appropriate for children and adults older than 6 years. The WASI has been shown to provide scores that are reliable with a full battery (i.e., WISC-IV) in samples of children ASD. The WASI also shows acceptable convergent reliability with both the WISC-IV and DAS in population-based samples (Wechsler, 2002).	Wechsler, D./ Psychological Corporation (2002). Manual for the Wechsler Abbreviated Scales of Intelligence. Austin, TX: Harcourt.
Stanford-Binet – Fifth Edition (SB-5) (Thorndike, Hagen & Sattler, 1986/2005).	The SB-5 is a standardized intelligence test designed for age 2-through older adulthood. It provides composite scores and overall IQ estimates and has excellent psychometric properties. The SB-5 has a brief IQ battery that is useful in research protocols.	Thorndike, Hagen & Sattler, 1986/Riverside, 2005. The manual for the Stanford-Binet Intelligence Scales. Los Angeles: Riverside.

NONVERBAL OR DIFFICULT TO ENGAGE STUDENT ASSESSMENT TOOLS (Sequenced Developmentally)		
Child Development Inventory (CDI) (Ireton, 1992).	The Ireton CDI is a 270-item family/caregiver checklist that covers 8 areas of development (social, self-help, gross motor, fine motor, expressive language, language comprehension, letters, and numbers) and is suggested for persons whose overall developmental level is approximately 6 years or less. Norms are available for chronologically young children and age equivalent scores can be derived for older individuals who are developmentally impaired. The CDI provides developmental estimates that are roughly equivalent to the results of standardized assessments of overall development. Common practice in research and clinical protocols is usually to attempt standardized assessment before moving to the CDI as the tool of choice.	Ireton, H. (1992). Child Development Inventory Manual. Minneapolis, MN: Behavior Science Systems

NONVERBAL OR DIFFICULT TO ENGAGE STUDENT ASSESSMENT TOOLS (Sequenced Developmentally)		
Leiter International Performance Scale-Third Edition (Leiter-3; Roid & Miller, et al, 2013)	The Leiter-R is a standardized nonverbal measure of intelligence, often used to estimate the nonverbal problem-solving potential of individuals who do not use speech. Several summary scores can be derived; most studies in autism research use the ''Brief IQ'', which can be obtained in less than an hour and is based on four subtests (Repeated Patterns, Sequential Order, Figure-Ground, and Form Completion). Convergent validity varies, but the Leiter may produce elevated scores, relative to the Wechsler tests.	Roid, G. H., & Miller, L. J. (2013). Leiter International Performance Scale, Third Edition. Western Psychological Sevices.
Peabody Picture Vocabulary Test – Fourth Edition (PPVT-4Dunn & Dunn, 2006)	The PPVT-4 is a commonly used standardized assessment of receptive language skills, and is frequently used as a proxy for overall intellectual functioning when assessing individuals with speech/language impairments (including articulation difficulties). It can be used across the lifespan and provides norm-referenced scores. Training is minimal and can be administered by someone with basic training in standardized testing.	Dunn, L. & Dunn, L. (2006). Peabody Picture Vocabulary Test-4. Pearson Publishing

COMMUNICATION, SPEECH AND LANGUAGE ASSESSMENT TOOLS		
MacArthur-Bates Communicative Development Inventories: Words & Gestures (CGI-WG) (Fenson et al, 1993; 2003)	The CGI-WG is a 4-page inventory of specific words and nonverbal acts that are important in the development of communication in young children. The family or educator/interventionist who knows the child completes the inventory which gives a developmentally informed snapshot of the child's current communicative profile (including both nonverbal and verbal acts of sending and receiving messages). Shown to be sensitive to treatment effects - it could be used as part of an IEP objective to measure a child's nonverbal communication before and after a year in school, for example. For children who are between 8 and 16 months old, the CGI can provide helpful qualitative information for students who are not yet effective communicators - either verbally or nonverbally, at just about any age. If using with a student who is older than 3, ask the family questions instead of giving it directly to the child, and skip sections not developmentally appropriate for an older, nonverbal student.	Fenson et al. (1993; 2003). MacArthur Communicative Development Inventories. San Diego: Singular Thompson Learning.
Peabody Picture Vocabulary Test – Fourth Edition (PPVT-4Dunn & Dunn, 2006)	The PPVT-4 is a commonly used standardized assessment of receptive language skills, and is frequently used as a proxy for overall intellectual functioning when assessing individuals with speech/language impairments (including articulation difficulties). It can be used across the lifespan and provides norm-referenced scores. Training is minimal and can be administered by someone with basic training in standardized testing.	Dunn, L. & Dunn, L. (2006). Peabody Picture Vocabulary Test-4. Pearson Publishing
Clinical Evaluation of Language Fundamentals-5 (CELF-5) (Semel, Wiig, & Secord, 2003)	The CELF-4 is a standardized comprehensive assessment of expressive and receptive language skills. Norms are available for children 5-17, with a companion measure for preschoolers. Two slightly different versions are administered to children aged 9-12 and 13-21. The CELF-4 is widely used in educational and clinical settings and generally demonstrates good psychometric properties. It is usually administered by a speech-language pathologist in clinical settings, but may be administered by a trained master's level clinician for research studies.	Semel, Wiig, & Secord, 2003. Manual for the Clinical Evaluation of Language Fundamentals – 4. Austin, TX: Psychological Corporation.

COMMUNICATION, SPEECH AND LANGUAGE ASSESSMENT TOOLS		
Children's Communication Checklist-2 (CCC-2) (Bishop 2003)	The CCC-2 is a 70-item checklist used to measure pragmatics (i.e., social-communication) that is completed by an adult who knows the child well (e.g., family, therapist, teacher). The CCC provides a total scaled score and ten normed subscales. A summary variable, The Social Interaction Deviance Composite (SIDC), may be derived from the Scaled Scores to consider whether or not a child is evidencing primarily structural or pragmatic language difficulties.	Bishop DVM. 2003. The Children's Communication Checklist version 2 (CCC-2). London: Psychological Corporation.

ASD SYMPTOMS SCREENING TOOLS		
Screening Tool for Autism in Two-Year Olds (STAT) (Stone et al, 2000; 2004)	The STAT is a brief interactive screening measure for use by early identification professionals. It is designed for toddlers ages 12-23 months. Comprised of a few play-based activities for screener to do with the child, accompanied by a very brief family interview, the STAT has very strong psychometric characteristics. It's been shown to be useful differentiating children at risk for ASD from those who are typically developing, as well as those who are developmentally delayed or have language disorders. Training and certification are necessary for responsible use. The STAT has been successfully adopted in statewide Part C efforts in several states.	Stone, W.L., Coonrod, E.E., Turner, L.M., & Pozdol, S.L. (2004). Psychometric properties of the STAT for Early Autism Screening. Journal of Autism and Developmental Disorders, 34(6), 691-701.
Infant-Toddler Checklist (ITC) (Wetherby & Prizant, 2002)	The Infant-Toddler Checklist is a 25-item checklist that was developed out of the SCERTS model of autism intervention and is very well attuned to the communicative aspects of ASD in young children. Designed and validated in a large community sample of children between 6 and 24 months, there is evidence for its effectiveness in screening children for overall developmental delay, as well as differentiating ASD from developmental delay (without ASD). It is a highly sensitive tool (i.e., won't miss many children), but may over-identify ASD in some cases.	Wetherby, A.M., Brosnan-Maddox, S., Peace, V., & Newton, L. (2008). Validation of the infant-toddler checklist as a broadband screener for autism spectrum disorders from 9 to 24 months of age. Autism, 12(5), 487-511. Wetherby, A., & Prizant, B. (2002). Communication and Symbolic Behavior Scales Developmental Profile–First Normed Edition. Baltimore: Paul H. Brookes, Wetherby & Prizant, 2002

ASD SYMPTOMS SCREENING TOOLS		
Modified Checklist for Autism in Toddlers (M-CHAT) (Robins et al, 2001)	The M-CHAT is a 23-item checklist designed for caregivers to complete. The goal of the tool is to try to differentiate between ASD and general developmental delays in young children. Best for children under the age of 3 years, the M-CHAT may also be helpful in screening children with known developmental disabilities as old as 10 years. Available at www.firstsigns.org.	Robins, D. L., & Dumont-Mathieu, T. M. (2006). Early screening for autism spectrum disorders: Update on the Modified Checklist for Autism in Toddlers and other measures. Journal of Developmental and Behavioral Pediatrics, 27 (Supplement 2), S111–S119. Robins, D. L., Fein, D., Barton, M. L., Greene, J. A. (2001). The Modified Checklist for Autism in Toddlers: An initial study investigating the early detection of autism and pervasive developmental disorders. Journal of Autism and Developmental Disorders, 31, 131–144.
Social Communication Questionnaire (SCQ) (Berument et al, 1999; Rutter, Bailey & Lord, 2003)	The SCQ is a 41-item yes/no family/caregiver checklist that has very strong scientific support as a screening tool for school-aged children. The SCQ was derived from a well-respected interview -- the Autism Diagnostic Interview-Revised (Lord et al, 1999). Although the ADI-R is thought to be part of a "gold standard" clinical/research evaluation for ASD, it is not thought to be an efficient tool for use in community settings The SCQ requires about 1/8th the time to administer (20 minutes vs. 2 hours) and does not require special training. Parents can complete it independently; however, follow-up discussion of items endorsed is recommended to be sure that the intent of the items was understood by the respondent. The SCQ is best for children 4 years and older; works best if the child has a developmental age of 2 years or older. May "miss" children who are very bright intellectually and have more subtle features; may also over-identify a child with significant developmental delays (and not ASD). There is some evidence it isn't as good a tool for assessing girls as boys. Available in Spanish and English; however, the Spanish version has been criticized for its lack of cultural competence. It is designed specifically for parents to complete, and although school staff can complete most items and provide qualitative information on the tool, it has not been validated for teacher report.	Berument, S.K., Rutter, M., Lord, C., Pickles, A., & Bailey, A. (1999). Autism Screening Questionnaire: Diagnostic validity. British Journal of Psychiatry, 175, 444–451. Rutter, M., Bailey, A., & Lord, C. (2003). Social Communication Questionnaire. Los Angeles, CA: Western Psychological Services.

ASD SYMPTOMS SCREENING TOOLS		
Social Responsiveness Scale (SRS) (Constantino et al, 2007)	The SRS is a 65-item family/caregiver checklist of children 3 years and older. SRS designed to differentiate between ASD and other psychiatric conditions. The SRS provides norm-based scores that help you to evaluate the person's risk for actually having an ASD and also allows for development of symptom lists. There are separate tools for males and females. The SRS is a good choice for a screening tool if the team is trying to differentiate ASD from an emotional/behavioral disability. Psychometrics are strongest in children 4-14 years and in samples of intellectually competent children.	Constantino, J.N., LaVesser, P.D., Zhang, Y., Abbacchi, A., Gray, T., & Todd, R.D. (2007). Rapid quantitative assessment of autistic social impairment by classroom teachers. Journal of the American Academy of Child and Adolescent Psychiatry, 46, 1668–1676.
Childhood Asperger Screening Test (CAST) (Baron-Cohen et al. 2002)	The CAST is a 37-item, family report checklist that is currently being used in the educational identification process in Great Britain. Originally designed for use in large epidemiological studies, the tool has been modified and tested in school settings, with promising results. Who its best for: Elementary-middle, school-aged children in general education settings who have not been identified with a significant intellectual impairment. It is not validated in children who are not using verbal speech. Most of the normative samples have been Caucasian, but do represent a broad sample of socioeconomic status. The CAST may be especially useful if there is concern about a differential between ASD and ADD/ADHD. Although it is not clear yet if it is useful for high school students, my review of the tool suggests it would provide qualitative information that will be useful, however, it is not known if the scoring algorithms will work as well with older students. How to get it: The CAST is available for free through: www.autismresearchcentre.com	Scott, F.J., Baron-Cohen, S., Bolton, P. & Brayne, C. (2002). The CAST (Childhood Asperger Syndrome Test): Preliminary Development of a UK Screen for Mainstream Primary-School-Age Children', Autism 6 (1): 9–31. Williams, J., Scott, F., Stott, C., Allison, C., Bolton, P., Baron-Cohen, S. & Brayne, C. (2005). The CAST (Childhood Asperger Syndrome Test): Test Accuracy, Autism, 9 (1): 45–68.
Asperger Syndrome Screening Questionnaire (ASSQ) (Ehlers et al, 1999)	The ASSQ is a teacher checklist of 27 items that was developed specifically for screening for high-functioning ASD in elementary & middle schools in Europe (Campbell, 2005; Posserud, Lundervold & Gillberg, 2006). Psychometric data are strong. For example, in an epidemiological study of the ASSQ in Sweden, all students with a medical diagnosis of Asperger syndrome obtained a score of 17 or higher on the ASSQ (Kadesjo et al, 1999). Few children without an ASD obtained scores this high, although some children with attention deficit disorders (and not ASD) also obtained relatively high scores on the ASSQ. As with all screening tools, further evaluation is necessary to differentiate an appropriate educational eligibility.	Ehlers, S., Gillberg, C., & Wing, L. (1999). A screening questionnaire for Asperger Syndrome and other high functioning autism spectrum disorders in school age children. Journal of Autism and Developmental Disorders, 29, 129–141.

ASD SYMPTOMS EVALUATION TOOLS		
Autism Diagnostic Interview-Revised (ADI-R) (Rutter et al. 2003)	The ADI-R is a semi-structured family interview that operationalizes DSM-IV and ICD-10 criteria for autism. Trained interviewers assess domains of social interaction, communication, and restricted, repetitive behaviors/interests. Onset status can be categorized well. The interview consists of over 100 questions. An algorithm has been established that differentiates autism from other developmental disorders at high levels of sensitivity and specificity (over .90 for both) for subjects with mental ages (MA) of 18 months and older. The ADI-R was developed as the parent interview companion measure to the ADOS. The ADI-R is used in research more than in clinical practice, due to the amount of time it requires to administer (as well as the amount of time for clinicians to become certified).	Rutter, M., Le Couteur, A., & Lord, C. (2003). Autism diagnostic interview-revised. Los Angeles: Western Psychological Services. Lord, C., Rutter, M. & LeCouteur, A. (1994). 'Autism Diagnostic Interview–Revised: A Revised Version of a Diagnostic Interview for Caregivers of Individuals with Possible Pervasive Developmental Disorders', Journal of Autism and Developmental Disorders 24 (5): 659–85.
Autism Diagnostic Observation Schedule (ADOS) (Lord, Rutter, DiLavore, & Risi, 2002)	The ADOS is thought to be the "gold standard" tool for direct observation of ASD symptoms. Designed for research and now integrated into clinical practice, the ADOS is comprised of 4 modules, arranged by language level. Administrators must complete training in administration and scoring before using. Revised algorithms now include a severity score, in addition to subscale scores, organized by symptom cluster (e.g., social-communication, repetitive activities). A standardized, semi-structured direct play/interview with the person suspected of having ASD. The reliability and validity of the ADOS are very strong (Lord, Rutter, DiLavore, & Risi, 2002; Risi et al, 2008), particularly when the person being evaluated has a nonverbal problem-solving developmental level of 12 months or higher. (At lower levels, the ADOS is less specific in differentiating ASD from intellectual impairment without ASD.)	Lord, C., Rutter, M., DiLavore, P.C., & Risi, S. (2002). Autism Diagnostic Observation Schedule. Los Angeles: Western Psychological Services.

ASSOCIATED FEATURES: MEASURES OF ASPECTS OF FUNTCTIONING (e.g., executive function, sensory responses, mental health issues, problem behaviors)		
Behavior Rating Inventory of Executive Functions (BRIEF) Preschool Version: Gioia, Espy, & Isquith, 2003; School-Age Version: Gioia, Isquith, Guy, & Kenworthy, 2000)	The BRIEF is an assessment of how executive functioning skills impact home, school and the community. Two different versions (Preschool and School-Age) allow for developmentally sensitive items across relevant areas of attention and self-regulation. Norms are provided for each of 9 subscales, as well as for a set of developmentally relevant factors that are thought to reflect global functioning. For preschoolers, the BRIEF provides subscale scores for Inhibit, Shift, Emotional Control, Working Memory, Plan/Organize and composite scores for Global Executive Composite, Inhibitory Self-Contol Index, Emergent Metacognition Index, and Flexibility Index. For school-aged children, the BRIEF provides subscale scores for Inhibit, Shift, Emotional Control, Initiate, Working Memory, Plan/Organize, Organization of Materials, and Monitor. Composite scores are computed for a Global Executive Index, Behavioral Regulation Index, and a Metacognition Index.	Gioia et al, (2003). Manual for the Preschool Version of the Behavior Rating Inventory of Executive Functions. Lutz, Florida: Psychological Assessment Resources. Gioia et al, (2000). Manual for the School-age Version of the Behavior Rating Inventory of Executive Functions. Lutz, Florida: Psychological Assessment Resources.
Emotion Regulation Checklist (ERC) (Shields & Cicchetti, 1997)	This is a brief (24-item) family/teacher report measure that provides information regarding a child's typical responses to emotionally intense experiences. The instrument has good reliability and validity across adult informants and provides indices regarding the child's ability to modulate and express affect in a manner that is context-appropriate.	Shields, A., & Cicchetti, D. (1997). Emotion-regulation among school-age children: The development and validation of a new Q-sort scale. Developmental Psychology, 33, 906-917.
Short Sensory Profile (SSP) (MacIntosh, Miller, Shyu & Dunn, 1999)	The SSP is a 38-item parent questionnaire designed to provide information about a child's sensory responses in daily life. Norming procedures for the SSP included a national US sample of 117 children and the measure shows high internal reliability (.91). The SSP is a brief version of the more extensive 125 item Sensory Profile assessment measure, and includes the domains: Tactile Sensitivity, Taste/Smell Sensitivity, Movement Sensitivity, Under-responsive/ Seeks sensation, Auditory Filtering, Low Energy/Weak, and Visual/Auditory Sensitivity.	McIntosh, D.N., Miller L. J., Shyu, V., & Dunn, W. The Sensory Profile: Examiner's Manual, 1999.
The Multidimensional Anxiety Scale for Children, Second Edition (MASC 2) (John S. March, MD, MPH)	This assessment is a 50-item, 4-point Likert-type scale of anxiety symptoms, designed for youth 8-19 years. It has a youth self-report and a parent report version. The MASC 2 has strong psychometric properties and preliminary evidence suggests it may also perform well in ASD samples. The MASC 2 measures the frequency (e.g., often true) of 50 thoughts, feelings or actions related to anxiety. The questionnaire should take approximately 15 minutes for the child to complete.	March, J.S. Multidimensional anxiety scale for children second edition. North Tonawanda, NY: Multi-Health Systems.
Children's Depression Inventory, Second Edition (CDI-2) (Kovacs, 2010)	This assessment is a brief, 27-item self-report screening tool for depression in youth (7 -19 years). A score of 13 or higher is indicative of significant risk of depression. Psychometric properties (internal consistency, test-retest reliability) are strong. Requires functional language ability of approximately 8 years to be valid.	Kovacs, M. (2010). Rating scales to assess depression in school-aged children. Acta Paedopsychiatrica, 46, 305-315.

ASSOCIATED FEATURES: MEASURES OF ASPECTS OF FUNTCTIONING (e.g., executive function, sensory responses, mental health issues, problem behaviors)		
Child Behavior Checklist (CBCL) (Achenbach, 2001)	The CBCL is an instrument by which parents or other individuals who know the child well rate a child's problem behaviors and competencies. There are two versions of the checklist one for children 18 -60 months and another for children 6-18. The CBCL is used to define child affective, anxiety, aggression, attention deficit/hyperactivity, conduct problems, bullying and defiance.	Achenbach, T. (2001). Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University Medical Education Associates.
The Developmental Behavioral Checklist (DBC) (Einfeld & Tonge, 1994)	The DBC is a 96-item checklist (each item scored on a 3-point likert scale) completed by parents or teachers to assess behavioral and emotional problems in children with a developmental disability. A Total Behavior Problem score is derived in addition to five subscale factor scores: Disruptive/ Antisocial behavior, Self-Absorbed Behavior, Communications Disturbance, Anxiety Problems and Social Relating Problems. The DBC is considered to have good reliability and validity (Einfeld & Tonge, 1994) and is sometimes used in intervention effectiveness studies on children with developmental disabilities, including autism. Two versions of the checklist are available: the Parent/Care version (DBC-P) and the Teacher version (DBC-T).	Einfeld, S. L., & Tonge, B. J. (1994). Manual for the developmental behaviour checklist. Clayton, Australia: Monash University Centre for Developmental Psychiatry and School of Psychiatry, University of New South Wales.
Aberrant Behavior Checklist (ABC) (Aman & Singh, 1994)	The ABC is a brief family/caregiver or teacher report checklist of externalizing and internalizing behaviors that is commonly used in studies of medication effectiveness.).	Aman, M. G., & Singh, N. N. (1994). Supplement to the Aberrant Behavior Checklist. East Aurora, NY: Slosson Educational Publications. Downloaded At: 22:35 16 February 2010Risk Markers and Correlates in ID,93.
Behavior Assessment System for Children (BASC-2) (Second Edition; Reynolds & Kamphaus, 2011)	The BASC-2 is a multi-informant assessment system that provides information concerning a child's adaptive and maladaptive behaviors across settings. Commonly used by school psychologists, the BASC is a developmentally sensitive instrument that provides standardized scores and estimates of significant risk across a range of internalizing and externalizing behaviors. Psychometric properties are strong.	Reynolds, C.R. & Kamphaus, R.W. (2011). Behavior assessment system for children – Second edition. San Antonio, TX: Pearson Corporation.

School Observation Guide

This table presents behaviors typically observed in students throughout the school day. Inconsistency, poor quality or the complete absence of these important behaviors could be indicators of ASD. This is not an exhaustive list. Please refer to the chart, Possible Signs of ASD for other behaviors that may indicate a possible autism spectrum disorder.

BEHAVIOR	DESCRIPTION	SPECIFIC EXAMPLES	BEHAVIORS OBSERVED
Social awareness or social orientation	The student notices that other people are present and shows more interest in people than objects.	• Looking up when others come near • Alerting when name is called • Walking through school halls without bumping into everyone • Facing teacher in circle time or during class (instead of turning away to look at the computer) • Playing with another child (instead of playing alone or with an object) • Realizing that when the teacher gives directions to the entire class, she is also talking to the him/her	
Sharing emotions with others	The student directs clear nonverbal cues towards others to let them know how he/she feels.	• Looking and smiling at someone else when something good happens • Frowning or making and “angry face” and directing the expression toward others to let them know he/she is frustrated	
Sharing attention with others (also called “joint attention”)	The student will follow someone else’s lead and look at what they want him to look at AND gives clear cues to others that he wants them to see what he sees.	• Monitoring another person’s eyes and following where their gaze shifts • Following another person’s pointing gesture • Using own eyes to shift back and forth between the person you are talking to and the thing you want them to see • Pointing to something to make sure someone else sees it	
Showing empathy for others	The student shows concern when someone else is sick, hurt or sad and will attempt to comfort a peer who is sad or frustrated.	• Patting a child who has fallen and saying “it’s okay” • Giving a stuffed animal to a child who is crying • Changing facial expression to show some concern or worry when someone else is upset or sad	

BEHAVIOR	DESCRIPTION	SPECIFIC EXAMPLES	BEHAVIORS OBSERVED
Using gestures (with or without words)	The student will deliver a message to another person by moving his/her hands, head or body in a motion that is well-understood in the student's particular culture (using gestures shows he naturally picked up some of the practices of his culture, this is an important indicator of social learning).	• Waving to indicate "goodbye" • Shrugging to indicate "I don't know" • Nodding head to indicate "yes" • Placing finder to lips to indicate "be quiet"	
Spontaneous communication	The student tries to send a message to another person (with or without words; with or without adaptive supports). The emphasis is on attempting to communicate without others reminding or requiring it.	• Commenting to another student that the homework was hard • Raising hand to ask a question or ask for help • Asking another person a question about their weekend • Asking an adult for a drink • Gesturing to another child to "come here"	
Flexible communication	The student tries different ways to send a message, especially if his/her listener doesn't seem to understand what he/she is trying to communicate AND not just sending the same message over and over again.	• Rephrasing a question so that others can better understand what she is trying to communicate • Using pantomime or acting out motions to clarify your meaning • Applying a change in intonation or the expressiveness of the voice to show what the student means or emphasize the most important part of the message • Asking a question once, perhaps seeking a little clarification, but not re-asking the same exact question	

BEHAVIOR	DESCRIPTION	SPECIFIC EXAMPLES	BEHAVIORS OBSERVED
Reciprocal communication	The student takes turns with another person in a back-and-forth exchange of verbal and/or nonverbal behaviors that involves fluidly shifting back and forth between listening and expressing.	• Two preschoolers discuss how many blocks belong on a tower: ◦ Sam:, "We need more." ◦ Ben: "No, 5 is good." ◦ Sam: "More will be taller and louder when it falls." ◦ Ben: (pause) Okay. Maybe 8." • Two middle school students discuss a recent history test: ◦ Harriet: "That was really hard." ◦ Sara: "Yeah, I didn't get the whole last part." ◦ Harriet: "Do you mean the stuff about Henry VIII?" ◦ Sara nods. ◦ Harriet: "Me either, I don't think she covered that in class."	
Flexible thinking	The student adjusts to the changes in expectations or routines without a lot of distress.	• Not becoming upset by having a substitute teacher • Transitioning: accepting an adult's request to leave a favorite activity (such as the computer) to do some other activity (such as joining a small group) • Accepting that different words can be used to mean a similar thing (i.e., there is no one way to express oneself). • Accepting that rules can be different in different places • Willingness to try a new way to solve a problem or play with something	
Enjoys a variety of interest and activities	The student is curious and willing to explore a broad range of ideas, subjects and activities. They listens to others talk about their area of interests.	Listening to another student's book report on a topic never before explored • Willingness to talk about a variety of topics without spending too much time on one particular topic • Willingness to watch another child use a toy in a way that is wasn't intended to be used. For example, watching a child move a block in the air proclaiming "it's a plane" without getting upset	

Summary of Results from Evaluation for ASD

Student's name: _____ Date of Birth: _____ Age: _____ Grade: _____
Screening Summary completed by: _____ Date of Summary: _____

SCREENING TOOL ASSESSMENT OBSERVATION INTERVIEW, ETC.	COMPLETED BY: (FAMILY, TEACHER, SPECIAL SERVICE PROVIDER)	LIST BEHAVIORS CONSISTENT WITH A POSSIBLE ASD	BEHAVIORS NOT CONSISTENT WITH A POSSIBLE ASD	DOES CHILD OBTAIN A SCORE INDICATING RISK FOR AN ASD?

Legal Name of Child	DOB	State Child ID (SASID)	Date

Determination of Eligibility: AUTISM SPECTRUM DISORDER

Definition: A child with an Autism Spectrum Disorder (ASD) has a developmental disability significantly affecting verbal and non-verbal social communication, social interaction, engagement in repetitive activities and stereotyped movements, and resistance to environmental changes or changes in daily routines which prevents the child from receiving reasonable educational benefit from general education. **ECEA 2.08(1)**

The team has addressed each of the following statements and has determined:
IDEA 34 C.F.R. §§ 300.304(c)(6) and 300.306(b), ECEA 2.08(1)

☐ Yes ☐ No 1. The evaluation is sufficiently comprehensive to appropriately identify all of the child's special education and related services needs, whether or not commonly linked to the disability category. (Answer must be "yes" in order for the child to be eligible for services.)

☐ Yes ☐ No 2. The child ***can*** receive reasonable educational benefit from general education alone. (Answer must be "no" in order for the child to be eligible for services.)

3. The child's performance: (All answers below must be "is not" in order for the child to be eligible for services.)

☐ ***Is*** ☐ ***Is Not*** due to a lack of appropriate instruction in reading, including the essential components of reading instruction

☐ ***Is*** ☐ ***Is Not*** due to a lack of appropriate instruction in math; and

☐ ***Is*** ☐ ***Is Not*** due to limited English proficiency.

To be eligible as a child with an Autism Spectrum Disorder, there must be evidence of the following criterion: ECEA 2.08(1)

Yes No A developmental disability significantly affecting verbal and nonverbal social communication and social interaction, generally evidenced by the age of three. Other characteristics often associated with Autism Spectrum Disorder are engagement in repetitive activities and stereotyped movements, resistance to environmental changes or changes in daily routines, and unusual responses to sensory experiences.

An Autism Spectrum Disorder, as described above, prevents the child from receiving reasonable educational benefit from general education as evidenced by all of the following criteria: ECEA 2.08(1)(a)

Yes No The child displays significant difficulties or differences or both in interacting with or understanding people and events. (Examples of qualifying characteristics include, but are not limited to: significant difficulty establishing and maintaining social-emotional reciprocal relationships, including a lack of typical back and forth social conversation; and/or significant deficits in understanding and using nonverbal communication including eye contact, facial expression and gestures); **and**

Yes No The child displays significant difficulties or differences which extend beyond speech and language to other aspects of social communication, both receptively and expressively.(Examples of qualifying characteristics include, but are not limited to: an absence of verbal language or, if verbal language is present, typical integrated use of eye contact and body language is lacking; and/or significant difficulty sharing, engaging in imaginative play and developing and maintaining friendships); **and**

Yes No The child seeks consistency in environmental events to the point of exhibiting significant rigidity in routines and displays marked distress over changes in the routine, and/or has a significantly persistent preoccupation with or attachment to objects or topics.

The child must meet each of the 3 eligibility criteria above to be eligible as a child with an Autism Spectrum Disorder. If the above criteria have been met, the following characteristics should be reviewed by the IEP team for further information about the ASD. These characteristics alone will not qualify a child as having an ASD: *Check all that apply.* **ECEA 2.08(1)(b)**

- ☐ The child exhibits delays or regressions in motor, sensory, social or learning skills; **and/or**
- ☐ The child exhibits precocious or advanced skill development, while other skills may develop at or below typical developmental rates; **and/or**
- ☐ The child exhibits atypicality in thinking processes and in generalization. The child exhibits strengths in concrete thinking while difficulties are demonstrated in abstract thinking, awareness and judgment. Perseverative thinking and impaired ability to process symbolic information is present; **and/or**
- ☐ The child exhibits unusual, inconsistent, repetitive or unconventional responses to sounds, sights, smells, tastes, touch or movement; **and/or**
- ☐ The child's capacity to use objects in an age appropriate or functional manner is absent or delayed. The child has difficulty displaying a range of interests or imaginative activities or both; **and/or**
- ☐ The child exhibits stereotypical motor movements, which include repetitive use of objects and/or vocalizations, echolalia, rocking, pacing or spinning self or objects.

☐ Yes ☐ No **The child has a disability as defined in the State Rules for the Administration of the Exceptional Children's Educational Act and is eligible for special education.**

Multidisciplinary Team Members **IDEA 34 C.F.R. § 300.306(a)(1); ECEA 4.02(6)(b)**	Title

Determination of Eligibility for ASD Worksheet

Assessment Summary Worksheet for the Educational Identification of an Autism Spectrum Disorder

Child/Student's Name: _____ Date of Birth: _____ Grade: _____

Teacher: _____ School: _____

Parent(s)/Guardian:_____

Date Worksheet Completed_____ Participating Members/ Titles_____

_____

Purpose of the Assessment Summary: To assist multidisciplinary teams to integrate and summarize the assessment findings to guide decision making. Eligibility determination must be based on multiple sources, both formal and informal, of assessment data.

Uses of this worksheet:

- To integrate and summarize assessment finding for the purpose of determining eligibility,
- As a guide for planning and/or reviewing the evaluation process, and
- To promote the development of educational programming.

Initial when completed.

1. _____Developmental profile that describes the child's historical and current features associated with ASD.

2. _____ Family interview including developmental and medical history.

3. _____Three observations (in multiple environments on at least two different days by at least two different observers, and at least one involving direct interaction with the child/student).

   a. Date: _____ Location: _____ Direct Interaction: Y N
   b. Date: _____ Location: _____ Direct Interaction: Y N
   c. Date: _____ Location: _____ Direct Interaction: Y N

4. _____ Communication assessment(s) which may include functional assessment, language sampling in the natural environment, assessment of semantics and pragmatics.

5. _____ Social engagement measuring functioning on formal assessment(s) and the natural environment.

6. _____ Behavior rating to identify characteristics associated with autism spectrum disorder.

7. _____ Educational assessment to determine the impact of the disability and need for specialized instruction.

8. _____ Other _____

Making the Eligibility Determination

To be eligible as a child with an Autism Spectrum Disorder, there must be evidence of the following criterion:

Criterion:	As Evidenced by:
A developmental disability significantly affecting verbal and non-verbal social communication and social interaction, generally evidenced by the age of three. Other characteristics often associated with Autism Spectrum Disorder are engagement in repetitive activities and stereotyped movements, resistance to environmental changes or changes in daily routines, and unusual response to sensory experiences., ECEA 2.08 (1)	

An Autism Spectrum Disorder, as described above, prevents the child from receiving reasonable educational benefit from general education as evidenced by all of the following criteria: ECEA 2.08(1)(a)

Criterion:	As Evidenced by:	Instructional Considerations:
The child displays significant difficulties or differences, or both in interacting with or understanding people and events. (Examples of qualifying characteristics include, but are not limited to: significant difficulty establishing and maintaining social-emotional reciprocal relationships, including a lack of typical back and forth social conversation; and/or significant deficits in understanding and using nonverbal communication, including eye contact, facial expression and gestures.		
The child displays significant difficulties or differences which extend beyond speech and language to other aspects of social communication, both receptively and expressively.(Examples of qualifying characteristics include, but are not limited to: an absence of verbal language or, if verbal language is present, typical integrated use of eye contact and body language is lacking; and/or significant difficulty sharing, engaging in imaginative play and developing and maintaining friendships)		
The child seeks consistency in environmental events to the point of exhibiting significant rigidity in routines and displays marked distress over changes in the routine, and/or has a significantly persistent preoccupation with or attachment to objects or topics		

The child must meet each of the three eligibility criteria above to be eligible as a child with an Autism Spectrum Disorder. If the above criteria have been met, the following characteristics should be reviewed by the IEP team for further information about the ASD. These characteristics alone will not qualify a child as having an ASD. ECEA 2.08(1)(b)

Criterion	As Evidenced by	Instructional Considerations
The child exhibits delays or regressions in motor, sensory, social or learning skills; and/or		
The child exhibits precocious or advanced skill development, while other skills may develop at or below typical developmental rates; and/or		
The child exhibits atypicality in thinking processes and in generalization. The child exhibits strengths in concrete thinking while difficulties are demonstrated in abstract thinking, awareness and judgment. Perseverative thinking and impaired ability to process symbolic information is present; and/or		
The child exhibits unusual, inconsistent, repetitive or unconventional responses to sounds, sights, smells, tastes, touch or movement; and/or		
The child's capacity to use objects in an age appropriate or functional manner is absent or delayed. The child has difficulty displaying a range of interests or imaginative activities or both; and/or		
The child exhibits stereotypical motor movements, which include repetitive use of objects and/or vocalizations, echolalia, rocking, pacing or spinning self or objects.		

Team Determination:	Comments: