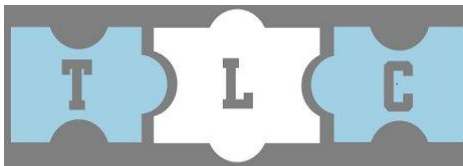


Treatment & Learning Center for Children with Autism
And
Autism Outreach Services



Referral Checklist

OFFICE: 903-593-4004

FAX: 903-593-4121

DATE: _____

Child's Name: _____

I. Behaviors: Rate presenting behaviors using a scale of 1 to 5, 1 = mild, 5 = severe

- _____ Physical aggression: hitting, kicking, spitting, scratching, slapping
- _____ Verbal aggression: cursing, yelling, screaming, name-calling
- _____ Non-compliance: refusing to comply with instructions, requests, etc.
- _____ Tantruming
- _____ Crashing: into solid objects, furniture, walls, property destruction
- _____ Injury to self
- _____ Unauthorized departure
- _____ Inappropriate sexual behavior (public masturbation, touching others)
- _____ Pica (ingestion of inedible substances)
- _____ Other (Please describe) _____

II. Communication: (check all that apply)

- _____ Communicates in full sentences _____ Uses phrases to communicate _____ Uses single words
- _____ Uses signs to communicate _____ Uses adaptive aids (such as sign book) _____ Uses sounds
- _____ Echolalic _____ PEC (Picture Exchange Communication)

IV. Family Situation: List information such as living situation, education, employment, health, marital status and relationship with referred consumer, willingness/ability to participate in program.

Mother: _____

Father: _____

V. Treatment and Learning Center services requested/recommended:

- _____ Behavior therapy program development for:
 - _____ decreasing inappropriate behavior
 - _____ teaching language
 - _____ teaching new skills
 - _____ Consult on toilet training
 - _____ Consult with public school program
 - _____ Other: (Describe) _____

