I. Goal

Each site is abstracting relevant information from the medical records of children who have an ASD diagnosis in their medical record. The goal of the clinician review is to look at the abstracted information for each child and determine the reliability of the ASD diagnosis.

II. DSM IV Criteria

Abstractors have been instructed to complete the DSM IV checklist on the abstraction form if a checklist was completed in the reviewed evaluation. If the checklist was not included in the evaluation and is not completed in the abstraction form, you, as the reviewer, may complete the checklist using information from the abstraction form. Per the DSM IV, to mark a criterion on the checklist, a behavior needs to be characteristic of the child rather than just exhibited once. This will be apparent through wording of the behavioral note or the fact that multiple observes noted behavior of this type.

Please note that this section is a work area for your own reference and will not be included in the final data collection. It is not easy to make these judgments so the skill/experience of the observer/examiner who noted the behavior is also important to consider. See the definition of a qualified professional on page 6.

A. DSM IV Checklist:

Social Interaction (A1)

Nonverbal Behavior (a)

Child displays a qualitative impairment in social interaction, as manifested by a marked impairment in the use of multiple nonverbal behaviors.

Examples:

- Does not make appropriate or consistent socially regulated eye contact (Note: differentiate from shyness, where child’s eye contact improves with time)
- Eye contact is only on own agenda (e.g., best with parents or only when making requests, does not make eye contact when introduced to others)
- Facial expressions are markedly flat/blank or inappropriate to situations (e.g., laughing when someone is hurt)
- Lack of or minimal use of conventional (e.g., nodding), instrumental (e.g., pointing) or descriptive (e.g., using hands to show size) gestures
- Turning away from people when interacting

Notes:

- Look for mentions of quality of eye contact in abstraction
- Quality of eye contact should be judged relative to length of exposure. For example, if child’s eye contact is noted as “inconsistent” in a 15-minute appointment with a pediatrician, this may not be enough information. If it is “inconsistent” in a 90-minute appointment with a psychologist, this would be
enough to mark the child as having this symptom, unless the lack of eye contact is due to another factor (e.g., anxiety).

- “Multiple” in this category means more than one behavior. So just a note of poor eye contact is not enough to qualify for the category. The child needs poor eye contact AND one other symptom e.g., marked impairment in gestures, etc. When a child is failing to make appropriate eye contact, they are also often not using their facial expressions and other nonverbal means to regulate social interactions. If they are not looking at you, they are not usually directing facial expressions appropriately, etc. to you either. However, that is an assumption, and may or may not be true. Look at the notes carefully. If lack of eye contact is the only symptom noted, this should be marked as "possible" or "some".

**Peer relationships (b)**
Child displays a qualitative impairment in social interaction, as manifested by a failure to develop peer relationship appropriate to developmental level.

*Examples:*
- Prefers to be alone
- Does not have an identified friend
- Prefers to be in the company of much older or younger children
- Often has difficulty initiating or sustaining interactions with peers
- Has difficulty in group activities (e.g., circle time, recess)

*Notes:*
- Look for parent report of difficulties in school or with peers, not having an identified friend
- Look for teacher reports on difficulties attending to circle time

**Spontaneous seeking (c)**
Child displays a qualitative impairment in social interaction, as manifested by a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people.

*Examples:*
- Does not bring things to parents to show them
- Does not talk about accomplishments or events unless asked
- When excited, does not look to see if parent or others are sharing in interest

*Notes:*
- Look for examples of parents reporting that the child is very good at playing by themselves, becoming very absorbed in activities, and being a “good baby” who did not cry or call attention to themselves
- Look for behavioral observations of children finding an activity in the office and not paying attention to what is happening during the appointment

**Emotional reciprocity (d)***
Child displays a qualitative impairment in social interaction, as manifested by a lack of social or emotional reciprocity.

*Examples:*
- Self-agenda orientation
- Cannot sustain reciprocal interactions when not on own agenda
- Difficulty understanding the perspective of others
• Difficulty with empathy

Notes:
• Look for notes about noncompliance in doctor’s visit or not being able to transition from preferred activities
• Look for behavioral observations of child being very “bossy” or not being able to understand another person’s feelings

Social impairment NOS (e)*
Child displays a qualitative impairment in social interaction, not otherwise specified.
*NOTE: Emotional reciprocity or social impairment or both meets only one criterion.

Communication (A2)

Spoken language (a)
Child displays a qualitative impairment in communication as manifested by a delay in, or total lack of, the development of spoken language, and no compensation with gestures or other ways of communicating (e.g., sign language, miming).
Examples:
• No single words used to label or request by age 12 months (i.e., words other than Mama or Dada or babbling)
• No phrase speech by 24 months (e.g., “big house”) [Note: be cautious about including commonly “chunked” phrases, such as “all done”]
• If a history of significant speech and language delay is present in the record, then it is always marked, even if the child is now a teenager and speaks in full sentences.

Conversational deficit (b)
Child displays a qualitative impairment in communication as manifested by a marked impairment in the ability to initiate or sustain a conversation with others. [Note: This criterion does not apply to children who do not have phrase speech]
Examples:
• Ability to engage in back-and-forth interaction with others is compromised
• Engages in “monologues” about topic of interest (e.g., talking “at” rather than “with” others)
• Cannot sustain a conversation about non-preferred subjects not related to own interests

Notes:
• Look for behavioral observations of child ignoring conversation prompts or talking excessively about a topic of interest without monitoring the other person’s interest level
• Look for parent reports of not being able to have the child tell them about their day, or not ever engaging in social chat (i.e., language is always for labeling or to have demands met)

Stereotyped and repetitive language (c)
Child displays a qualitative impairment in communication as manifested by the stereotyped and repetitive use of language or idiosyncratic language.
Examples:
• Immediate or delayed echolalia
• Reciting scripts inappropriately
• Idiosyncratic speech (e.g., insisting on calling a triangle “mashuda”)
• Overly formal speech
• Consistently inappropriate prosody, intonation, rhythm, rate, or volume

Notes:
• Look for behavioral observations of child echoing questions or asking for things in question form (e.g., “Give you” when asking for something instead of saying “give me”)
• Look for behavioral observations of child sounding like a “little professor”
• Look for behavioral observations of odd sounding speech (e.g., mechanical, odd rhythm)

Imaginative play (d)
Child displays a lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

Examples:
• Does not use objects as independent figures (e.g., an understanding that the figure represents a living figure outside of the child)
• Does not imitate others (e.g., parents) or incorporate imitation into play
• Play is mostly stereotyped and repetitive
• Lack of interest in social games (e.g., peekaboo)

Notes:
• Look for parent report of history of no interest in playing baby games
• Look for clinicians having difficulty in engaging them with toys other than books or board games

Communication imp NOS (e)
Child displays a qualitative impairment in communication, not otherwise specified.

Restricted Behavior (A3)
Restricted interests (a)
Child displays a preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

Examples:
• Intense interest in abnormal item or object (e.g., Target maps, car seats)
• Interest is encompassing in that it restricts child’s ability to engage in other activities or toys
• Interest causes problems for families (e.g., cannot go into store if there are elevators, avoids any place with water fountains)
• Knows facts about interest and spends a lot of time thinking about it, learning about it, or talking about it (e.g., dinosaurs, bugs, Thomas the Train)
• Watches the same video over and over again

Notes:
• Look for parent report of preoccupation with odd things or with particular toys (e.g., Thomas the Train, Star Wars, Hannah Montana, Dora the Explorer)
• Look for behavioral observations of child holding onto odd things (e.g., plastic fencing, sticks)

**Routines and rituals (b)**
Child displays an inflexible adherence to specific, nonfunctional routines or rituals. [Note: Do not include bedtime routines]

*Examples:*
• Difficulties transitioning between activities
• Plans cannot be changed if the child has been told
• Insistence on schedule (e.g., dinner is at 6:00PM exactly)
• Insistence on certain items being a certain way (e.g., doors closed, lights off, sitting in a certain spot)
• Verbal rituals (e.g., apologies are said in a certain way)
• Insistence on sitting in the same place, using one particular bowl

*Notes:*
• Look for behavioral observations of child insisting on cleaning up toys in clinician’s office in a certain way, greeting clinician in a certain way, etc
• Look for behavioral observations of consistent difficulties transitioning into and out of room

**Stereotyped mannerisms (c)**
Child displays stereotyped and repetitive mannerisms.

*Examples:*
• Hand flapping, rocking, midline hand movements, hand wringing, finger posturing, finger flicking, head banging, muscle tenseness, facial grimacing, etc.
• These behaviors are often seen when child is excited, anxious, or overstimulated
• NOTE: Head banging and other self-injurious behavior may not qualify as stereotyped behavior if it is not being done for self-stimulation.

**Preoccupation with parts (d)**
Child displays a persistent preoccupation with parts of objects.

*Examples:*
• Engages with object in sensory-based way
• Sighting (i.e., visual examination), looking at things out of the corners of eyes
• Plays with parts of toys rather than the whole (e.g., opening and closing car door)
• Consistently licks or puts things in mouth or against face (e.g., chewing on shirt)
• Touches or rubs things inordinately (e.g., earlobes, surfaces, blankets)

**Restricted behavior NOS (e)**
Child displays restricted, repetitive and stereotyped patterns of behavior, not otherwise specified.

**B. DSM IV ASD Dx criteria are as follows:**
1. **Autism** - A child must have at least 6 DSM-IV TR behaviors coded with at least 2 in Social (A1) and 1 in Communication (A2) and 1 Behavior Criteria (A3), and evidence of Developmental Delay before 3 years of age;

2. **ASD-NOS** - A child has at least the number and pattern for one of the following:
   - **PDD-NOS**: DSM IV TR of at least 1 criterion in Social (A1) and either 1 Communication (A2) or 1 Behavior (A3)scored a-d; or
   - **Asperger's Disorder**: DSM IV-TR of at least 2 criteria in Social (A1) and at least 1 in Behavior (A3).

If you have enough information from the abstraction form to complete the DSM IV checklist and the child meets criteria for Autism, PDD-NOS, or Asperger's Disorder, this justifies a “confirmed case” for the Final ASD Case Definition.

### III. Final ASD Case Definition

Consider all of the information available to make a final determination from options 1-5 listed below. Some abstraction forms may not include a lot of behavior information. Please consider all of the following when reviewing abstraction forms:

- Use of DSM IV Criteria in the evaluation
- Extent of evaluation – what assessments and other procedures were used (even if scores or summaries are not listed)
- Qualifications of the provider(s) who conducted the evaluation
- What you know about the facility where the evaluation took place
- Number of evaluations completed for the child

There are five options for final case definition:

1. Confirmed ASD Case
2. Probable Case
3. Possible Case
4. Not a case (does not qualify after review)
5. Insufficient information available to make a decision

**OPTION 1: Confirmed ASD Case**  
*ASD Reviewer classification: ___Autism       ___ASD-NOS*

Mark this option only if a DSM IV checklist was completed in the abstracted record and child qualifies as having an ASD diagnosis, or there was sufficient information in the abstracted record so that you could complete a DSM IV checklist and at minimum, the child qualifies as having an ASD diagnosis. Refer to
Section II.B (page 5) for more information. Another way to think of this option is that the diagnosis is fully documented in the records.

**OPTION 2: Probable Case**

A probable case is one where documentation is incomplete so that the reviewer cannot independently verify that DSM IV criteria have been met. However, the dx was made by a credible source and the clinician states clearly that DSM IV criteria were used to make the dx. There may also be behaviors described allowing a partial independent completion of the DSM IV checklist and/or ASD assessments listed. Another way to think of this option is that the diagnosis is adequately documented in the records.

E.g. Choose this option if the following three statements are true:

1. A **qualified professional** diagnosed the child with an ASD
2. No DSM IV checklist was available in the abstraction form and there is not enough behavioral description to thoroughly complete a DSM IV checklist
3. The abstraction form states that the provider used the DSM IV and/or used autism-specific assessments to diagnose the child

A **qualified professional** is an MD Pediatrician, Child Psychiatrist, Child Psychologist, School Psychologist, Neurologist, or a Mental Health Clinician with specific expertise in this area.

If a **qualified professional** diagnosed the child and you cannot complete a DSM IV checklist and there is no information at all about whether or not the DSM IV was used or any autism-specific assessments were used to evaluate the child, then this would **NOT** qualify as a probable case.

**OPTION 3: Possible Case**

A Possible Case is one where you think the child may have an ASD, but from the information available, you cannot be sure that the child would qualify using the DSM IV checklist. Another way to think of this category is that there is suggestive evidence beyond just a listed diagnosis in the record. A case would be considered “Possible” if any of the following 4 statements are true:

1. Some ASD behaviors are listed so that you could partially check-off a DSM IV checklist, but the described behaviors are not enough to confidently complete the checklist **AND** either of the following are true:
   - There is no statement that DSM IV criteria were met; or
   - The abstraction form lists that the DSM IV checklist and/or ASD specific assessments were used to give the child a diagnosis but the person who gave the diagnosis is not a **qualified professional** (a qualified professional is an MD Pediatrician, a Child Psychiatrist, Child Psychologist, School Psychologist, Neurologist, or a Mental Health clinician with specific expertise in this area).
2. There was enough information listed to complete a DSM IV checklist, but the behaviors listed were based on parent report only and not reported as seen by a clinician during an encounter.

3. There is conflicting information: it is recorded in some encounters that a child exhibits behaviors consistent with ASD and then other encounters state the child specifically does not exhibit these behaviors, qualified professionals disagree on the diagnosis (ASD or non-ASD), or the behavior that the parents report is not consistent with behavior observed by the clinician.

4. The only information available is a parent’s report that the child was evaluated for ASD and diagnosed with an ASD by a believable third party qualified professional, and there is no confirming evidence (such as copies of evaluations or even summary letters from that respected source)

**OPTION 4: Not a Case (Does Not Qualify After Review)**

a. **Could be accounted for by other disorder(s)**
   The abstraction form states that the child has been diagnosed with other (non-ASD) disorders that would account for the listed behaviors and suspicions of ASD.

b. **Sufficient information to R/O ASD**
   The child was assessed or evaluated by a qualified professional and there was sufficient evidence to determine the child does not have ASD. This means that the qualified professional used the DSM IV and/or autism-specific assessments, and/or there were behavioral descriptions in the abstraction form that indicate the child does not have an ASD.

c. **Other – specify:**
   Choose this option if you believe the child is not a case and does not qualify after review, but for reasons not described in the three other options.

**OPTION 5: Not Enough Information Available**

Mark this option if you can’t fill out the DSM IV criteria as present or absent and there is not enough information about how the child received a diagnosis to mark the child as possible or to rule-out a diagnosis. Another way to think of this is that there is no evidence beyond the listing of a diagnosis in the record.

**Example:** A child was given an ASD diagnosis made by someone other than a qualified professional and no behaviors or reasoning are listed.

**IV. Reviewer Degree of Impairment**

If you chose options 1 or 2 (confirmed or probable case), complete question #3: Reviewer Degree of Impairment

*Reviewer Degree of Impairment associated with ASD: 1(Mild) 2 3 4 5 (Severe)*
This rating is a subjective rating of the severity of symptoms associated with an ASD by the reviewer. The rating should be a general rating to summarize the child’s social, communication, behavioral, and adaptive functioning based on all information contained in the abstracted records that relates to core and associated symptoms of an ASD. The degree of impairment associated with ASD should be made independently of cognitive level of functioning, if possible.

1 2 3 4 5
Mild Moderate Severe

**Mild:** The child shows only a few symptoms or only a mild degree of autism.*
The child has fewer ASD symptoms, either in number or degree, than children with moderate or severe autism. ASD symptoms do not prevent the individual from taking part in most activities of daily living or inclusive educational or community events. The individual may need some modifications and support to participate in activities, but is often able to do so with these supports.

**Moderate:** The child shows a number of symptoms or a moderate degree of autism.*
The child has persistent difficulty in social, educational, or community functioning that affects his or her ability to participate most of the time without modifications or support. Without regular modifications or supports, the individual would be noticeably limited by his or her communication, social, or behavioral symptoms.

**Severe:** The child shows many symptoms or an extreme degree of autism.*
The child has persistent and significant difficulties in social, educational, or community functioning. The child usually needs environmental modifications or the assistance of another person to participate in most activities of daily living, education, or the community.

*Definitions from the “XV. General Impressions” rating on the *Childhood Autism Rating Scale (CARS)*.

V. Reviewer Rating of Quality and Quantity of Information

Using the five point scale described below, please rate the overall quality and amount of information abstracted for this case based on the usefulness of this information in confirming or ruling out the presence of an ASD. 1 2 3 4 5

*Unacceptable* *Poor* *Adequate* *Good* *Excellent*

1 The abstracted information is *so limited* that there is insufficient information to make any determination about whether the child could have an ASD (child could not score as an ASD Case. Reason: insufficient information). For example, the abstraction form indicates only one behavioral observation in a 15-minute pediatrician well-check appointment where a young child showed difficulties with transitioning into the pediatrician’s office and made no eye contact.

2 There is *neither* enough information nor information of acceptable quality to confirm or rule out presence of an ASD.
3 There is *either* enough information or the information is of acceptable quality to be *reasonably* sure that the child does or does not have an ASD.

4 There is *either* enough information or the information is of acceptable quality to *clearly* confirm or rule out presence of an ASD.

5 There is *both* enough information and the information is of acceptable quality to confirm or rule out presence of an ASD.

**VI. Review Comments**

Make any comments you think are relevant and may impact the child’s case status.
APPENDIX 1 – EXAMPLE ABSTRACTION FORM AND EXPERT REVIEW

FOR EXPERT REVIEW EXAMPLE

Medical Record Abstraction Form

Section 1a: Basic Abstraction – Identifiers (in a Separate File)

MRN: _xxxxx_______
Child Name: ___xxxxx_____
Birthdate: __xxxx________
StudyID _99040_______
Notes _HISTORY OF DX IN RECORD:

2/20/08  29980-003  Aspergers  PSY____Specialty: General

Section 1b: Basic Abstraction

Abstractor name: _xx___ Date of Abstraction: xx____ StudyID: 99040

Section 2: ASD Encounters (All) - Each SID may have multiple Encounters

1. Location of Record:  HealthConnect____
2. Date of Encounter: 2/20/08
3. Facility of Encounter: _San Francisco
4. Department of Encounter:  Psychiatry_sub-department_child/adol psych_
5. Name of provider:  xxxx
6. Specialty/Degree of provider:  Psychologist
7. Was this encounter a primary evaluation? Yes  N

7.a) If No: If this encounter did not include a primary evaluation, but a review of a previous evaluation was used to give child a diagnosis, indicate specific diagnosis or diagnoses given by clinician during encounter that reviewed evaluation:
<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASD</td>
</tr>
<tr>
<td></td>
<td>Asperger’s Disorder</td>
</tr>
<tr>
<td></td>
<td>Atypical Autism</td>
</tr>
<tr>
<td></td>
<td>Autistic Disorder</td>
</tr>
<tr>
<td></td>
<td>PDD-NOS</td>
</tr>
<tr>
<td></td>
<td>Rhett’s Disorder</td>
</tr>
<tr>
<td></td>
<td>CDD</td>
</tr>
<tr>
<td></td>
<td>Other (list):</td>
</tr>
</tbody>
</table>

_____ _____ child did not receive a diagnosis during this visit

__________ non-ASD diagnosis

8. Type(s) of Evaluation(s) to abstract associated with this encounter – check all that apply:

_ ASD Evaluation
_ ASD return evaluation
__Development evaluation by developmental pediatrician
__Speech therapy evaluation
__OT evaluation
__Psych intake evaluation
__Psych return appointment
__Medication evaluation
__IEP
__Educational assessment
__Other evaluation: ______________
__Other evaluation: ______________
Section 3: Evaluation

(This section will repeat according to the number of evaluations checked above.)

1. Type of Evaluation:
   __ ASD Evaluation
   __ ASD return evaluation
   __ Development evaluation by developmental pediatrician
   __ Speech therapy evaluation
   __ OT evaluation
   Psych Intake evaluation
   X Psych return appointment
   Medication evaluation
   __ IEP
   __ Educational assessment
   __ Other evaluation: ______________

2. Date of Evaluation  2/20/08

3. Name of Examiner 1: ______xx_____ Specialty/Degree of Examiner 1: psychologist
   Name of Examiner 2: ________ Specialty/Degree of Examiner 2: ________
   Name of Examiner 3: ________ Specialty/Degree of Examiner 3: ________
   Name of Examiner 4: ________ Specialty/Degree of Examiner 4: ________
   Name of Examiner 5: ________ Specialty/Degree of Examiner 5: ________
   Name of Examiner 6: ________ Specialty/Degree of Examiner 6: ________
   Name of Examiner 7: ________ Specialty/Degree of Examiner 7: ________

4. Facility of Evaluation: San Francisco

5. Department of Evaluation: child/adol_Psychiatry (e.g. pediatrics/child psych/ASD Center)

6. Chronologic age of child at evaluation: 12
7. If referred, reason for referral: -

8. Verbatim description of delay or developmental concern prior to age 3:

9. Verbatim description of regression or plateau in development at any age:

10. Verbatim ASD behavioral descriptions:
Pt reportedly does not like the Thursday group meeting dad reports. I told dad pt has not been to the last two groups//Went over ASPERGERS DISORDER WITH PT'S FATHER//Dad says Aspergers disorder has been ruled out (dad reports a $3500) testing by Boden and Associates. Went over DX with father and father reported that he did not think his son has Aspergers. //Talked with pt's dad about ADHD and medications. Dad adamant that he does not want pt on meds //Began the process of going over BEHAVIORAL interventions for ADHD//Dad says he prepares lunch and pt's clothes and did not hear my suggestion for pt to take on more of the responsibility in the home. //Pt's dad says he shines his son's shoes.//Dad says he does not see a lot of organizational problems but more distraction problems with his son. //Pt has been fascinated with dinosaurs (since the early age). Pt knows all the names of the Dinosaurs and knows all about fossils (started when pt was in Kindergarten). //Dad denies pt ever had a marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction. However, pt does show evidence of this in group. Dad feels pt struggles with eye contact due to his wife having the same deficit.//Pt reportedly does not have friends who come over to visit on a regular basis.

11. Verbatim non-ASD behavioral descriptions:
Dad reports pt does Sylvan (2x a week) and that it is going well.//Pt has gone to open houses for high school. (Saint Ignacio)./Dad says pt has friends in the boy scouts./Dad reports pt organizes his own backpack well. Dad reports pt's room is organized and pt makes his own bed./Dad reports pt does take out the garbage, goes to Sylvan by himself and walks the dog./Dad reports pt never had a history of finger or hand flapping./Pt recently won a science award from the Randall Museum. // Pt is also in boy scouts and doing push ups and sit ups at night. Pt also earned an altar boy medal dad reports./Pt talks every day on the phone with friends through the computer. Dad denies the persistent preoccupation with parts of objects (any history of). Pt started having friends in Kindergarten. Dad also reports pt did not get upset with changes in routine -now or in the past. //Suicide: no risk Homicide: no risk//Pt currently has three friends from school dad reports.

12. Prior diagnoses noted in evaluation:
Medical: Qualifier
- N/A
- Down's Syndrome ____
- Epilepsy/Seizure Disorder ____
- Fetal Alcohol Syndrome ______
- Fragile X Syndrome ______
- Tuberous Sclerosis ____
- Other genetic or chromosomal conditions: ______
- Significant hearing loss ______
- Significant visual impairment
- Cerebral Palsy

Psych – DSM IV Disorders usually diagnosed in infancy or childhood:

- N/A
- ADHD/ADD
- Mental Retardation – severity
- Motor Skills Disorder
- Expressive Language Disorder
- Mixed Receptive-Expressive Language Disorder
- Phonological Disorder
- Stuttering
- Communication Disorder NOS
- Conduct Disorder
- Oppositional Defiant Disorder
- Tourette’s Disorder
- Chronic Motor or Vocal Tic Disorder
- Transient Tic Disorder
- Tic Disorder NOS
- Separation Anxiety Disorder
- Selective Mutism
- Reactive Attachment Disorder
- Stereotypic Movement Disorder
- Other psych disorder

Evaluation summary diagnosis/impression:

ASSESSMENT:

Issues of domestic violence continue to be major issue. This issue does not seem to be getting better by father’s report since the couple started therapy together. Pt has been inconsistent in group. Due to problems with eye to eye gaze and strong interest in Dinosaurs and lack of emotional spontaneity and sharing, I have asked pt to be seen by the ASD team. I left a message today with Dr. B and will wait to hear her impressions on whether pt should be evaluated by the ASD team. Pt needs to continue with group due to poor peer interactions.

DIAGNOSIS:

Axis I: See HealthConnect diagnosis

Axis II: See HealthConnect diagnosis

Axis V: 51 - 60 moderate symptoms due to chronic exposure to DV issues.

Encounter Diagnoses

Code Name Primary? Qualifier
• V61.10A PROBLEM IN MARITAL OR PARTNER RELATIONSHIP, COUNSELING  Yes
• 314.01A ATTENTION DEFICIT HYPERACTIVITY DISORDER
• 299.80B ASPERGERS DISORDER Rule Out
• V62.81E PEER PROBLEMS.

13. Is there a statement on record that the child met DSM IV criteria for ASD? 
   /NO

14. Is there a statement on record that the child DID NOT meet DSM IV criteria for ASD? 
   NO

15. DSM IV Checklist (mark only if recorded by evaluator):

   Social Interaction (A1)
   - Nonverbal Behavior (a)
   - Peer relationships (b)
   - Spontaneous seeking (c)
   - Emotional reciprocity (d)
   - Social impairment NOS (e)

   Communication (A2)
   - Spoken language (a)
   - Conversational deficit (b)
   - Repetitive language (c)
   - Imaginitive play (d)
   - Communication imp NOS (e)

   Restricted Behavior (A3)
   - Restricted interests (a)
   - Routines and rituals (b)
   - Stereotyped mannerisms (c)
   - Preoccupation with parts (d)
   - Restricted behavior NOS (e)
16. Indicate specific diagnosis or diagnoses given by clinician during evaluation/visit:

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
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<tr>
<td>______ ___</td>
<td>Rhett’s Disorder</td>
</tr>
<tr>
<td>__________</td>
<td>CDD</td>
</tr>
</tbody>
</table>

X Other (list): __ATTENTION DEFICIT HYPERACTIVITY DISORDER, PEER PROBLEMS., Primary?

• V61.10A  PROBLEM IN MARITAL OR PARTNER RELATIONSHIP

______ ____ non-ASD diagnosis

______ ____child did not receive a diagnosis during this visit

17. Did the evaluation include (check all that apply):

_x_ List of behaviors

_x_ List of diagnoses (Axis I, II, III)

_x_ Evaluation Summary Diagnosis/Impressions

__ Autism Test Results

__ Intelligence/Developmental Test Results

__ Adaptive test results

__ Academic progress report

__ IEP progress report

X Other supporting evidence (Describe): _BODEN and Associates findings.

18. DSM4  Dx symptom checklist for Parent/Teacher Instruments used in the evaluation (check all that apply):
Autism Instruments:

__Autism Diagnostic Interview
__ADI-R - Autism Diagnostic Interview Revised
__ADOS - Autism Diagnostic Observation Schedule, Module: ___
__ASDI - Asperger Syndrome Diagnostic Interview
__ASDS - Asperger Syndrome Diagnostic Scale
__ABC - Autism Behavior Checklist
__ASIEP- Autism Assessment Pragmatic & Nonverbal Behavior Checklist
__Autism Screening Instrument for Educational Planning (1st or 2nd ed)___CARS - Childhood Autism Rating Scale (1st or 2nd ed.)
__CADS – Children’s Atypical Development Scale
__GARS, GARS-2 - Gilliam Autism Rating Scale
__GADS - Gilliam Asperger Disorder Scale
__ASAS - Australian Scale for Asperger Syndrome
__ASQ – Autism Screening Questionnaire
__ATEC – Autism Treatment Evaluation Checklist
__ASSQ - Autism Spectrum Screening Questionnaire
__CAST - Childhood Asperger Syndrome Test
__KADI - Krug Asperger’s Disorder Index
__SCQ - Social Communication Questionnaire, current or lifetime ___
__DISCO - Diagnostic Interview for Social and Commun. Disorders
__Direct Observation Checklist: Autism Spectrum Disorders
__MIGDAS – Monteiro Interview Guidelines for Diagnosing Asperger’s Syndrome
__PIA – Parent Interview for Autism (or Clinical Version)
__PDD Behavior Inventory
__Pervasive Dev Disorders Screening Test-II (PDDST-II)
__Pre-Linguistic ADOS (PL-ADOS)
__Preschool Autism Rating Scale
__RBS – Repetitive Behavior Scale (or Revised version)
Intelligence and Developmental Tests

__SRS – Social Responsiveness Scale
__TEACCH Functional Abilities Scale

__Mullen Scales of Early Learning
__Ages and Stages Questionnaire (ASQ)
__Stanford-Binet Intelligence Scales, 5th Ed.
__Differential Ability Scales, 2nd ed. (DAS-II) early years or school age
__Developmental Profile, 3rd ed. (DP-3)
__WPPSI III
__WISC-IV
__WISC nonverbal
__WAIS-IV
__WASI
__Kaufman (KABC) – II
__Kaufman (KBIT) – II
__Leiter R
__Merril Palmer R
__Bayley III
__WIAT-III – The Wechsler Individual Achievement Test
__NEPSY-II A Developmental Neuropsychological Assessment
__CELF-4 Clinical Evaluation of Language Fundamentals
__WRAML2 Wide Range Assessment of Memory and Learning
__VMI- Beery Buktenica Developmental Test of Visual-Motor Integration
__BRIEF – Behavioral Rating Inventory of Executive Function

Adaptive Tests

__Vineland II Adaptive Behavior Scales
__Developmental Behavior Checklist (DBC)
Adaptive Behavior Assessment System, 2nd ed. (ABAS II)
Achenbach Child Behavior Checklist (CBCL)
1. DSM IV Checklist (optional):
   Social Interaction (A1)
   __X__ Nonverbal Behavior (a)
   - Dad denies pt ever had a marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction. However, pt does show evidence of this in group. Dad feels pt struggles with eye contact due to his wife having the same deficit.
   - Due to problems with eye to eye gaze and strong interest in Dinosaurs and lack of emotional spontaneity and sharing, I have asked pt to be seen by the ASD team.
   __Peer relationships (b)
   - Pt reportedly does not have friends who come over to visit on a regular basis.
   - Pt talks every day on the phone with friends through the computer.
   - Pt started having friends in Kindergarten.
   - V62.81E PEER PROBLEMS
   __Spontaneous seeking (c)
   - Due to problems with eye to eye gaze and strong interest in Dinosaurs and lack of emotional spontaneity and sharing, I have asked pt to be seen by the ASD team.
   __Emotional reciprocity (d)
   - Due to problems with eye to eye gaze and strong interest in Dinosaurs and lack of emotional spontaneity and sharing, I have asked pt to be seen by the ASD team.
   __Social impairment NOS (e)

Communication (A2)

__Spoken language (a)
__Conversational deficit (b)
__Repetitive language (c)
__Imaginitive play (d)
__Communication imp NOS (e)
Restricted Behavior (A3)

_X_Restricted interests (a)

- *Pt has been fascinated with dinosaurs (since the early age). Pt knows all the names of the Dinosaurs and knows all about fossils (started when pt was in Kindergarten)*

__Routines and rituals (b)

- *Dad also reports pt did not get upset with changes in routine -now or in the past.*

__Stereotyped mannerisms (c)

- *Dad reports pt never had a history of finger or hand flapping.*

__Preoccupation with parts (d)

__Restricted behavior NOS (e)

2. Final ASD Case Definition:

___ Confirmed ASD Case: ASD Reviewer classification: ___Autism ___ASD-NOS

___Probable Case

_X Possible Case

- Clinician has seen the child in a group setting and is noting red flags for an ASD. However, father seems to be denying a lot of symptomotology and so it is difficult to tell from the abstraction what is really going on. The difficulties with nonverbal communication, social/emotional reciprocity, and restricted interest in dinosaurs make it seem likely that the child is on the spectrum.

___ Does Not Qualify After Review

Could be accounted for by other disorder(s)

Sufficient information to R/O ASD

Other – specify:

___Not Enough Information Available

If checked Confirmed or Probable Case for #2, then complete #3:

3. Reviewer Degree of Impairment associated with ASD: (Mild) 1 2 3 4 5 (Severe)

4. Reviewer rating of quality and quantity of record: (poor) 1 2 3 4 5 (excellent)

*It is very difficult to tell from the abstraction what is going on with the child. Some of the information seems to be contradictory and it is unclear how forthcoming the father is being, or if there are ulterior motives due to the domestic violence component.*

5. Comments: