North Dakota Autism Database Report Form
Children's Special Health Services
ND Department of Health
600 E. Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200
701.328.4832 or 1.800.755.2714
SFN xxxxxx (9/26/2014)

REGISTRATION INFORMATION

☐ New ☐ Update

INSURANCE INFORMATION

☐ None ☐ Private ☐ Medicaid ☐ Other ☐ Unknown

INDIVIDUAL'S INFORMATION

NAME OF INDIVIDUAL (AS APPEARS ON BIRTH CERTIFICATE)

Last Name | Suffix

First Name | Middle Name

ALSO KNOWN AS

Last Name | Suffix

First Name | Middle Name

INDIVIDUAL'S CURRENT RESIDENCE ADDRESS

Street Address

Unit Description | Unit Number | PO Box

City | State

Zip code | County | Country

Social Security Number | Telephone Number ( )

HOSPITAL/PLACE OF BIRTH

Medical Facility Name

City | State | Country

PRIMARY CARE PROVIDER

Provider Name or Practice Name (Last, First) ☐ Undecided ☐ Unknown

City | State | Zip code

Telephone Number ( )

BIRTH INFORMATION

Date of Birth / /

Sex ☐ Female ☐ Male ☐ Indeterminate

Birth Weight

_____ Grams –OR- _____ Lbs., _____ Oz. –OR- ☐ Unknown

Plurality ☐ Single ☐ Other Multiple ☐ Twin ☐ Unknown

Father's age at time of delivery _____

Mother's age at time of delivery _____

Weeks of Pregnancy ☐ Preterm (<37 Wks.) ☐ Post Term (≥42 Wks.) ☐ Term (37-41 Wks.) ☐ Unknown

Birth Order

ETHNICITY INFORMATION

Hispanic/Latino ☐ Yes ☐ No ☐ Unknown

Primary Language Spoken in Home ☐ English ☐ Spanish ☐ Other, Specify: _____

Race *(Check ALL that apply)*

☐ White ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ Unknown

BIRTH MOTHER'S RESIDENCE AT TIME OF INDIVIDUAL'S BIRTH

If mother was institutionalized at time of birth, enter residence address before she was institutionalized

☐ Unknown ☐ Same as individual's current residence address

Street Address

Unit Description | Unit Number | PO Box

City | State

Zip code | County | Country

PARENT/GUARDIAN INFORMATION (A)

☐ Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Legal Guardian

Vital Status ☐ Alive ☐ Dead ☐ Unknown

Sex ☐ Female ☐ Male

Biologically Related to Individual ☐ Yes ☐ No ☐ Unknown

PARENT/ GUARDIAN NAME

Last Name | Suffix

First Name | Middle Name

Maiden Name

MAILING ADDRESS

☐ Same as individual's current residence address

CHILDREN'S SPECIAL HEALTH SERVICES REGISTRATION (CONTINUED)

PARENT/GUARDIAN INFORMATION (A), CONTINUED

Street Address

Unit Description	Unit	PO Box

City	State

Zip code	County	Country

Date of Birth	Telephone Number
/ /	( )

ETHNICITY INFORMATION

Hispanic/Latino
☐ Yes ☐ No ☐ Unknown

Race *(Check ALL that apply)*
☐ White ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ Other and unknown

PARENT/GUARDIAN INFORMATION (B)

☐ Parent ☐ Adopted Parent ☐ Foster Parent ☐ Legal Guardian

Vital Status
☐ Alive ☐ Dead ☐ Unknown

Sex	Biologically Related to Individual
☐ Female ☐ Male	☐ Yes ☐ No ☐ Unknown

Last Name Suffix

First Name	Middle Name

Maiden Name

MAILING ADDRESS

☐ Same as individual's current residence address

Street Address

Unit Description	Unit Number	PO Box

City	State

Zip code	County	Country

Date of Birth	Telephone Number
/ /	( )

ETHNICITY INFORMATION

Hispanic/Latino
☐ Yes ☐ No ☐ Unknown

Race *(Check ALL that apply)*
☐ White ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ Unknown

DIAGNOSTICIAN INFORMATION

Name of Individual Making Diagnosis (Last, First)

Doctoral Level Professional
☐ MD/DO ☐ Doctorate

Specialty:
☐ Family Practice ☐ Nurse Practitioner ☐ Psychology
☐ Geneticist ☐ Pediatrics ☐ Other, Specify: _____
☐ Neurology ☐ Psychiatry _____

I verify that I am experienced in the field of autism spectrum disorder, including intellectual testing and other formal evidenced-based assessments for autism spectrum disorders ☐ Yes ☐ No

PRACTICE/FACILITY WHERE DIAGNOSIS MADE

Practice/Facility Name

Department/Unit

Street Address

Unit Description	Unit	PO Box

City	State

Zip code	County	Country

Telephone Number
( )

INFORMATION ON PERSON SUBMITTING REPORT

Relationship to Person Being Registered
☐ Diagnostician or Diagnostician's Staff ☐ Other Health Care Provider
☐ Case Manager ☐ Other, Specify: _____

Title
☐ Dr. ☐ Mr. ☐ Ms.

Name (Last, First)

CONTACT INFORMATION (IF DIFFERENT FROM DIAGNOSTICIAN)

Practice/Facility Name

Department/Unit

Street Address

Unit Description	Unit	PO Box

INFORMATION ON PERSON SUBMITTING REPORT, CONTINUED

City | State

Zip code | County | Country

Telephone Number

( )

REGISTRATION INFORMATION FOR INDIVIDUAL

Last Name | First Name

Date of Birth / /

Sex ☐ Female ☐ Male ☐ Indeterminate

DIAGNOSIS INFORMATION FOR THIS REGISTRATION FORM

Diagnosis using **DSM-IV** *(choose one)*

Autism Spectrum Disorders:

- ☐ Asperger Disorder
- ☐ Autistic Disorder
- ☐ Childhood Disintegrative Disorder
- ☐ Pervasive Developmental Disorder NOS
- ☐ Rett Syndrome

Diagnosis using **DSM-V**: Autism Spectrum Disorder (ASD)

Severity Levels: *(choose one)*

- ☐ Level 3: "Requiring very substantial support"
- ☐ Level 2: "Requiring substantial support"
- ☐ Level 1: "Requiring support"

Instruments/References Used *(check all that apply)*

☐	ABC	Autism Behavior Checklist
☐	ADI-R	Autism Diagnostic Interview-Revised
☐	ADOS	Autism Diagnostic Observation Schedules
☐	CARS	Childhood Autism Rating Scale
☐		Clinical Impression
☐	DSM-IV-R	Diagnostic and Statistical Manual 4th Ed.., Revised
☐	GADS	Gilliam Aspergers Disorder Scale
☐	GARS-2	Gilliam Autism Rating Scale
☐	M-CHAT	Modified Checklist for Autism in Toddlers
☐	PDDST-II	Pervasive Developmental Disorder Screening Test-II
☐	SCQ	Social Communications Questionnaire
☐	STAT	Screening Tool for Autism in Two Year Olds
☐	SRS	Social Responsiveness Scale
☐	Other, Specify:	_____

AUSTISM HISTORY

Date of Diagnosis / /

Age Symptoms First Noted by Anyone _____ Yrs. _____ Mos. ☐ Unknown

SIBLING INFORMATION

Any Siblings Diagnosed with Autism

☐ Yes ☐ No If so, how many: _____

EACH DIAGNOSED SIBLING SHOULD BE REGISTERED ON A SEPARATE FORM

CLINICAL OBSERVATIONS

DECREASED SOCIAL INTERACTIONS

- ☐ Lack of non-verbal skills (i.e., Facial expressions, body posture, etc.)
- ☐ Failure to establish friendships with individuals of the same age
- ☐ Lack of interest in sharing enjoyments, interests, or achievements
- ☐ Lack of empathy

DECREASED VERBAL AND NONVERBAL COMMUNICATION

- ☐ Delay in, or lack of, learning to talk
- ☐ Problems taking steps to start a conversation
- ☐ Stereotyped and repetitive use of language
- ☐ Difficulty understanding their listener's perspective

LIMITED INTERESTS IN ACTIVITIES OR PLAY

- ☐ Unusual focus on parts of toys/objects rather than the whole toy/object
- ☐ Preoccupation with certain objects (i.e., video games, trading cards, etc.)
- ☐ A need for sameness and routine
- ☐ Stereotyped behaviors (i.e., body rocking, hand flapping, etc.)

Complete Physical Evaluation by a licensed physician

Physical Evaluation completed	☐ Yes	☐ No
Hearing Test Done	☐ Yes	☐ No
Have Excluded Organic Causes	☐ Yes	☐ No
Other, Specify: _____	☐ Yes	☐ No

Co-morbidities *(check all that apply)*:

☐ ADHD	☐ Obesity
☐ Asthma	☐ OCD
☐ Depression/Bipolar/Mood	☐ ODD
☐ Feeding Disorders	☐ Schizophrenia
☐ GERD or other Gastro Conditions	☐ Seizures/Epilepsy
☐ Hydrocephalus	☐ Sleep Disorders
☐ Intellectual Disability	☐ Tic Disorders
☐ Microcephaly	

MEDICATION(S) CURRENT OR FORMER USE

Stimulants

- ☐ Ritalin/Concerta/Daytrana/Focalin (methylphenidate)
- ☐ Catapres (Clonidine)
- ☐ Adderall (Amphetamine-dextroamphetamine)

Neuroleptics

- ☐ Risperdal (Risperidone)
- ☐ Abilify (Aripiprazole)
- ☐ Seroquel (Quetiapine)

Antidepressants

- ☐ Prozac (Fluoxetine)
- ☐ Zoloft (Sertraline)
- ☐ Lexapro (Escitalopram)

Anticonvulsants

- ☐ Depakote (Divalproex sodium)
- ☐ Lamictal (Lamotrigine)

Anxiolytics

- ☐ Buspar (Buspirone)
- ☐ Ativan (Lorazepam)