

Guidelines for the Educational Evaluation of Autism Spectrum Disorder

Exceptional Student Services Unit

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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 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. A 2020 report from the Autism and Developmental Disabilities Monitoring Network (ADDM) estimated 1 in 54 young children have 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 – IIR 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.

Words underlined and in blue print are hyperlinked to websites or other places in this document. Hold the control (Windows) or command (Mac) key and click on the word or phrase.

Practices identified in these Guidelines are particularly relevant for:

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

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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, and guidelines from other states across a range of eligibility categories.
4. Discussions with school professionals in Colorado from 2002-2020, 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, and nurses) 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 2020.

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Section 1: 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. ASD results from early-altered brain development and neural reorganization (Lord et al., 2018) It is considered 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 certain patterns of behavior 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. 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 may 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). Some research has shown young children later diagnosed with ASD imitated with objects first, whereas children with other developmental delays (and typically developing children imitate gestures and body movements first. 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,” which means ASD affects each person in different ways, and can range from mildly to greatly impacting a person's daily life functioning. People with ASD share similar symptoms, such as problems with social interaction and restricted interests or repetitive behaviors, 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.

ASD begins in early childhood and lasts throughout a person's life, though symptoms may improve over time. Some children with ASD show signs 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 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

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.

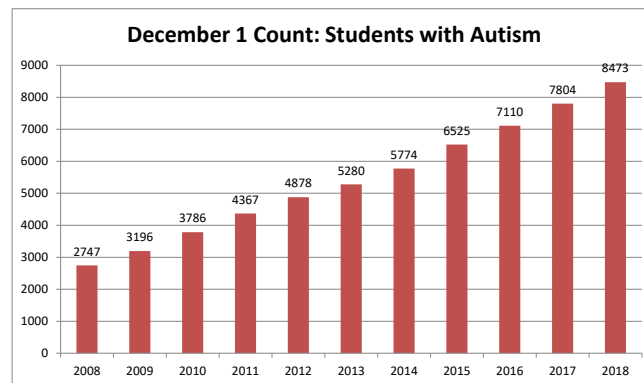
In contrast, a child with a history of unevenly developing skills, that appears to follow an unexpected developmental sequence, with different rates of skill acquisition across different skills is usually described as a child with a developmental disorder; not a developmental delay.

- 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 language development. 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. Though the exact cause is unknown and there are likely multiple pathways to ASD, ASD is highly heritable and genetics play a large role in the likelihood/cause of ASD. Brain imaging research has demonstrated children with ASD have structural and functional abnormalities in their brain which result in cognitive and neurological abnormalities, manifesting as behavioral differences (Minschew & Williams, 2007). Early intervention can improve both developmental functioning and the quality of life for the individual and their family, and the earlier these interventions are received, the more significant and better the long-term outcomes are for the individual (Dawson et al., 2010; Warren et al., 2011).

There has been a steady increase in the prevalence of ASD since the mid-1990s. The Centers for Disease Control and Prevention (CDC) reported that 1 in 54 young children have autism spectrum disorder (Maenner, et al., 2020). 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, and (c) more consistency by CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network in the method used to count ASD cases. 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. Young students with ASD may be counted as having a Developmental Disability. A child with a co-occurring emotional disorder may have been determined to have a Serious Emotional Disability, or a student may still have the label of Physical Disability. Students with ASD and an Intellectual Disability may be placed in the category of Multiple 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 Language Impairment or Intellectual Disability. As the new disability categories, described in the next section, begin to be implemented, these data may change.

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 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 atypical 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. 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, odd hand mannerisms, and pacing), and repetitive play with objects (such as lining up toys but not really playing with them).

There may also be a 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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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 • Limited repertoire of play activities
3 Years	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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, particularly around anything new or that is a change • Preoccupation with rules, fairness, & justice
12 - 18 Years (Middle & High School)	<ul style="list-style-type: none"> • 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: [Autism Navigator 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)] Social, communication, and other deficits of ASD must also be addressed. 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 of autism spectrum disorder?

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 on the next page 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 their 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. Administrative unit personnel may not require a medical diagnosis before determining a student eligible for special education services.

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 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.



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.
- 2.8 (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.

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)

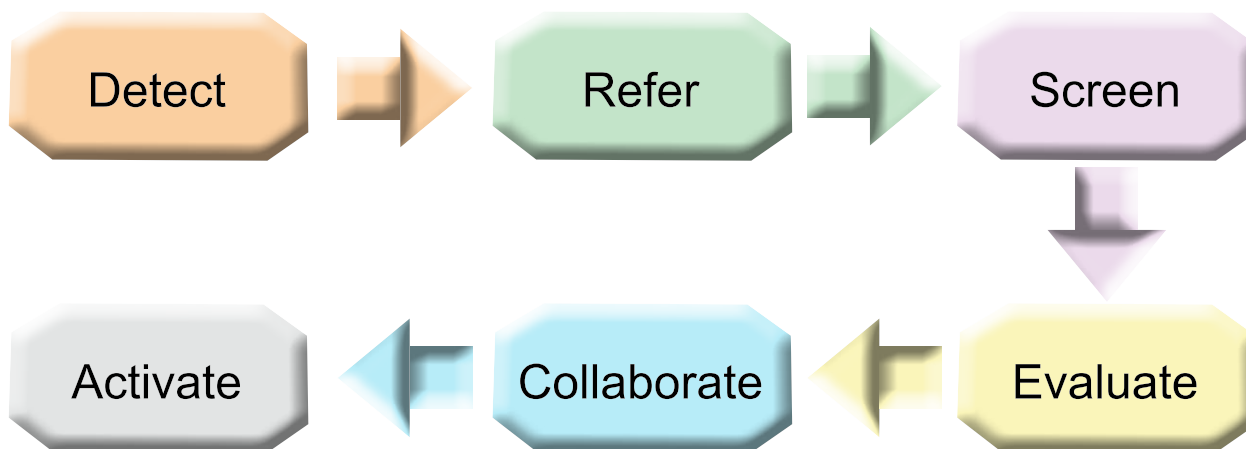
D. Symptoms together limit and impair everyday functioning.

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	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▫ standardized assessments of intellectual functioning, language, motor skills, learning style, adaptive behaviors ▫ existing educational record and medical/ clinical reports, as provided by family 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▫ 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	Between 6-18 months in local clinics; possibly 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 must impair everyday functioning to be clinically diagnosed.
Results are intended for:	Developing the student's Individualized Education Program, (including identifying appropriate educational goals and objectives, accommodations, 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.

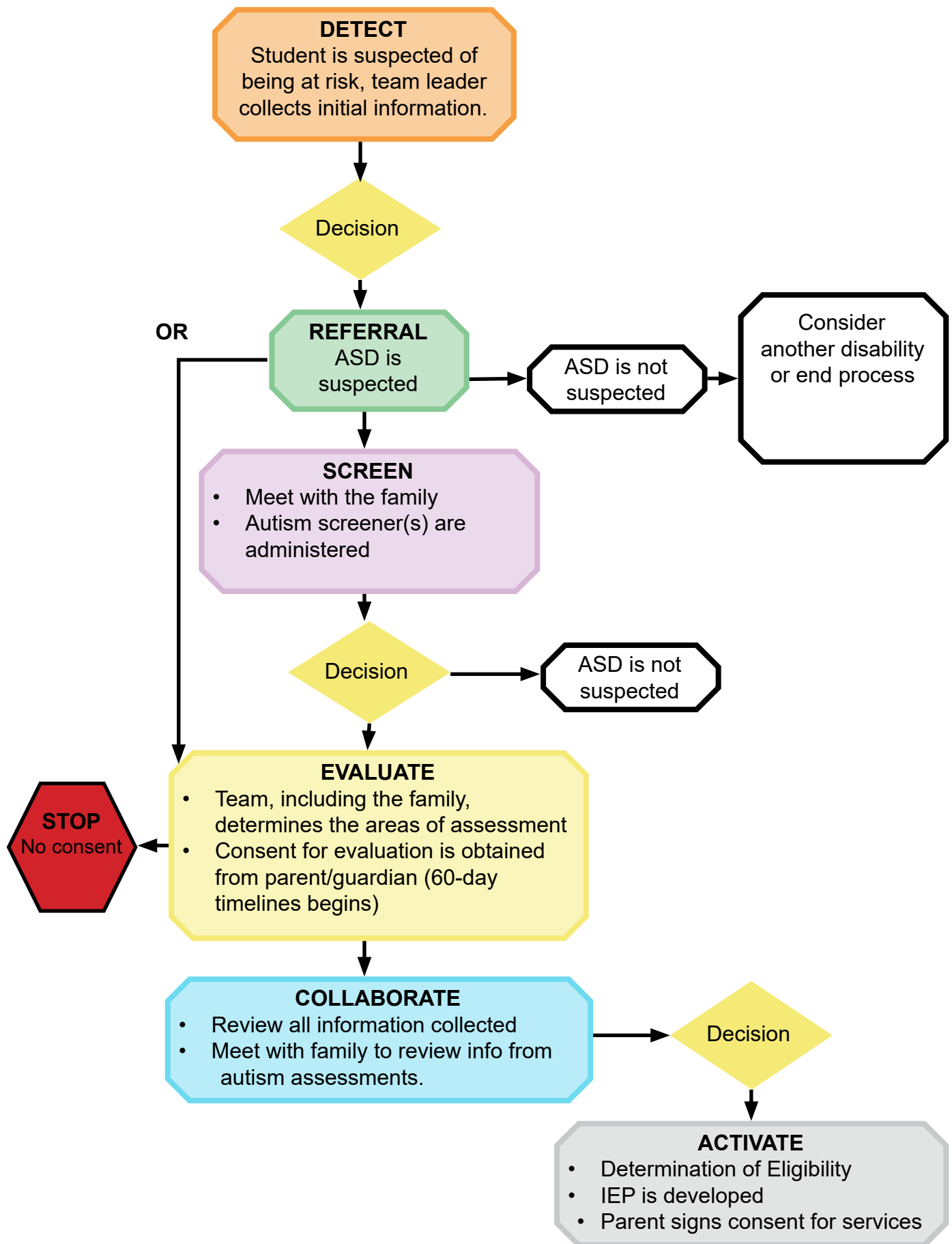


Each component has a particular goal within the educational identification process:

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](#) about young children with and without ASD. Early identification should lead to timely access of effective interventions and services. Therefore, information and training for general educators, as well as special educators is essential for early detection. 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. 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 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). OSEP 11-07 RTI process cannot be used to delay - deny evaluation for eligibility under IDEA. 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 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. 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 evaluation and a plan for the next steps can be developed. If it is decided the child does not have the features associated with ASD, this initial process could eliminate unnecessary evaluations and worry for the family.

2.3

Screen

“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. 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 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) or other agency responsible for the evaluation of young children for Part C services. When a child is referred for an evaluation, the family may contact either the CCB/agency 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, and the presence of restricted interests or repetitive behaviors. Refer to the “[Red Flags](#)” chart at the beginning of this document for more characteristics by age.

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 Questionnaire*
- 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 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 Section III, for additional screening instruments for all ages and an example of a [Developmental History Questionnaire](#).

2.4 Evaluate

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? (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 15 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
- 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 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 [ASD Evaluation Tools](#) in Section III for a list of assessments to examine the core features of autism, including social and communication deficits, restricted interests/repetitive behaviors, and other possible associated features. To learn more about these tools, please attend the "ASD Educational Evaluation Toolkit Training." Find out more here: http://www.cde.state.co.us/cdesped/sd-autism_pd.

- 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 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 the child easily coordinate their eyes, facial expressions, and/or gestures with their verbal communication?).

- Administration of an assessment tool specific to autism, such as the *Autism Diagnostic Observation Schedule, 2nd Edition* or the *Autism Diagnostic Interview - Revised*, 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.

Note: See the [ASD Evaluation 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. 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. 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 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 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?
- When thinking of restricted areas of interest or repetitive behavior, consider the level of intensity, frequency and duration to which that behavior interferes with everyday life.

If the data indicate features of ASD in the three areas 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

Collaborate

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.

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.

- 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.

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 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.



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, 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.

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.



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."*

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.

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

EVALUATE – Mr. and Mrs. Adams are 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 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.

Example Forms

[Autism and Behavior Consultation Team Referral Form](#)

[Developmental History Questionnaire](#)

Screening and Assessment Tools

[Communication Tools](#)

[ASD Screeners](#)

[Social Tools](#)

[ASD Evaluation Tools](#)

[Tools for Restricted Interests/Repetitive Behaviors and Associated Features](#)

[Determination of Eligibility: AUTISM SPECTRUM DISORDER](#)

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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

Ohio Center for Autism and Low Incidence Disabilities (OCALI): <http://www.ocali.org/>

National Professional Development Center on ASD: <https://autismpdc.fpg.unc.edu/national-professional-development-center-autism-spectrum-disorder>

For video clips of children with and without ASD at different ages and developmental levels, see: <https://autismnavigator.com/asd-video-glossary/>

For handouts for parents and colleagues about autism (fact sheets, developmental milestones, etc.), see: <https://www.cdc.gov/ncbddd/autism/materials/index.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: <https://sites.ed.gov/idea/regs/b/d>

For a list of eligibility categories and their definitions: <https://sites.ed.gov/idea/regs/b/a/300.8>

For an assessment toolkit development by the Office of Special Education Programs (OSEP): <https://osepideasthatwork.org/federal-resources-stakeholders/tool-kits/tool-kit-teaching-and-assessing-students-disabilities>

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

American Academy of Pediatrics Toolkit for Evaluating Children for Autism: <https://shop.aap.org/autism-caring-for-children-with-autism-spectrum-disorders-a-resource-toolkit-digital-download>

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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>

For materials about ASD in Spanish, see:

<https://www.cdc.gov/ncbddd/Spanish/autism/index.html>

<https://www.autismspeaks.org/espanol>

Autism and Behavior Consultation Team

Referral Form

Referral Date: _____ Student: _____

Date of Birth: _____ School: _____

Age: _____ Grade: _____ Teacher: _____

Parents Name(s): _____

Phone(s): _____

Email(s): _____

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 or 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 return this form to: _____

ASD Referral Information Form

Referral Date: _____ Student: _____

Date of Birth: _____ School: _____

Age: _____ Grade: _____ Teacher: _____

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 safety			
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 safety in more detail. If there 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 your knowledge, have there been any significant changes in the student's life - any major transitions or traumatic events in the past few years?

Who are the family members that communicate with the school?

How have 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

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 materials, in planning an appropriate educational program and 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. PREGNANCY 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 Assessment Tools

COMMUNICATION TOOLS		
Clinical Evaluation of Language Fundamentals-5 (CELF-5) (Semel, Wiig, & Secord, 2013)	The CELF-5 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-5 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, 2013. Manual for the Clinical Evaluation of Language Fundamentals – 4. Austin, TX: Pearson Publishing
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). San Antonio, TX: Pearson Publishing.
Pragmatic Language Checklist	The Pragmatic Language Checklist is an assessment based on an observation checklist and is for ages 4 and older. It looks at general conversation and nonverbal conversational skills.	Cobb Count School System; Marietta, GA
Conversation Effectiveness Profile – Revised (CEP-R)	The CEP-R is a checklist for kindergarteners through adults measuring the appropriateness of behavior within conversations. It reviews social interactions, social communication, and social-emotional regulation.	Kowalski, T. (2010). Social Pragmatic Success for Asperger Syndrome and Other Related Disorders. Orlando, FL. Professional Communication Services.
The Communication Matrix	The Communication Matrix is an assessment tool designed to pinpoint exactly how an individual is communicating and to provide a framework for determining logical communication goals. It can be very helpful when looking at assistive devices. It builds on the foundation of communication.	C. Rowland, Communication Matrix (Rev. ed.), Oregon Health and Science University, Design to Learn Projects, Oregon, 2004.
Social Communication Skills – The Pragmatic Checklist	The Social Communication Skills Pragmatic Checklist is a 45-item questionnaire that assesses how children use communication skills. It targets students between the ages of 2 and 7. Though it was initially designed for students with a hearing loss, it can be used for students with ASD.	Goberis, D. (1999) Pragmatics Checklist (adapted from Simon, C.S., 1984).
Test of Pragmatic Language (TOPL-2)	Test of Pragmatic Language evaluates social communication in context, telling the examiner how well the student listens, chooses appropriate content, expresses feelings, and makes requests. Administration time is 45-60 minutes.	Phelps-Teraski, Phelps_Gunn,, 2007. Test of Pragmatic Language, Second Edition. Torrance, CA: WPS Publishing

COMMUNICATION TOOLS

<p>Social Language Development Test - Elementary and Adolescent</p>	<p>The Social Language Development Test has four sub tests requiring student to make inferences, interpret photographed scenes, and explain how they would resolve problems with peers. Administration is 45 minutes. Ages 6.0-17.11.</p>	<p>Bowers, L., Huishings, R. LoGiudice, C., 2016. Social Language Development Test-Elementary, Adolescent – 4. Austin, TX: PRO-ED Publishing</p>
<p>Clinical Assessment of Pragmatics (CAPs)</p>	<p>Clinical Assessment of Pragmatics is a video based assessment with 6 subtests providing comprehensive information on pragmatic language skills and social development of children and young adults. Administration time is between 45-60 minutes. Ages 7-18.</p>	<p>Lavi, A. 2019. Clinical Assessment of Pragmatics. Torrance, CA. WPS Publishing</p>
<p>Social Emotional Evaluation (SEE)</p>	<p>The SEE presents typical social situations and common emotional reactions that elementary and middle school students frequently encounter. It is ideal for identifying social and emotional language needs of students with ASD, emotional disorders, learning disabilities or attention deficit disorders. Administration time is 20-25 minutes for students between 6-13 years of age.</p>	<p>Wiig, E. 2008. Social Emotional Evaluation (SEE). North Tonawanda, NY. Mental Health Assessments</p>

ASD SCREENERS

<p>Screening Tool for Autism in Two-Year Olds (STAT) (Stone et al, 2000; 2004)</p>	<p>The STAT is a brief interactive screening measure for use by early childhood professionals. It is designed for toddlers ages 12-36 months. Comprised of a few play-based activities for the 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. A training tutorial is included in the test kit.</p>	<p>Stone, W.L., & Ousley, O. (2004). Tennessee: Vanderbilt University Kennedy Center.</p>
<p>Infant-Toddler Checklist (ITC) (Wetherby & Prizant, 2002)</p>	<p>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.</p>	<p>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. Baltimore, MD: Brookes Publishing. Free.</p>

ASD SCREENERS

<p>Modified Checklist for Autism in Toddlers (M-CHAT) (Robins et al, 2001)</p>	<p>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.</p>	<p>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. <i>Journal of Developmental and Behavioral Pediatrics</i>, 27 (Supplement 2), S111– S119.</p> <p>Free online.</p>
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SOCIAL TOOLS

<p>Social Communication Questionnaire (SCQ) (Rutter, Bailey & Lord, 2003)</p>	<p>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.</p> <p>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.</p>	<p>Rutter, M., Bailey, A., & Lord, C. (2003). <i>Social Communication Questionnaire</i>. Los Angeles, CA: Western Psychological Services.</p>
<p>Social Responsiveness Scale (SRS) (Constantino et al, 2007)</p>	<p>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.</p> <p>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.</p>	<p>Constantino, J.N., LaVesser, P.D., Zhang, Y., Abbacchi, A., Gray, T., & Todd, R.D. (2007). <i>Social Responsiveness Scale</i>. Los Angeles, CA: Western Psychological Services</p>

SOCIAL TOOLS

Assessment of Social Skills for Children Autism (Quill, 2000)	A checklist designed for school-aged children. It was developed to help drive intervention and reviews the presence of skills and the generalization of those skills.	Adapted from Do-Watch-Listen-Say: Social and Communication Intervention for Children with Autism by Kathleen Ann Quill (2000). Paul H. Brookes Publisher.
Social Interaction Observation Form	This form was designed to be used with preschoolers through adults. It is a structured observation form that outlines specific typical social behaviors. Observations either support these behaviors or detail atypical interaction.	Lake County, MC; www.co.lake.mn.us
Structured Student Interview - Asperger Syndrome	This structured interview is for any verbally fluent children. It is an informal interview used to elicit responses that may help understand how the student thinks about social information. It can be used to capture social difficulties, and is helpful in determining restricted interests.	Dunn Buron, K (2011).
Triad Social Skills Assessment	This is a criterion-based assessment that looks at knowledge and skills in the social skills domain. The assessment kit has parent and teacher rating scales as well as direct child interaction activities. It assesses cognitive, behavioral, and affective abilities.	Brigham, N.B. (2013). TRIAD Social Skills Assessment . In: Volkmar, F.R. (eds) Encyclopedia of Autism Spectrum. Springer, New York, NY.
NEPSY-2	The NEPSY-2 is a neuropsychological tool that includes a social perception domain. This domain includes affect recognition and theory of mind subsets that may provide insight into a student’s ability to recognize emotion or comprehend other’s perspectives, intentions, and beliefs. It is for verbal students, ages 3-16, and needs to completed by a school psychologist.	Brooks, Sherman, & Strauss (2010). ‘NEPSY-II: A Developmental Neuropsychological Assessment, 2nd Ed., Child Neuropsychology, 16:1, 80-101
School Assessment Rating Scale for Asperger’s Syndrome	This is a free rating scale designed for students K-12. It can help identify behaviors and abilities indicative of autism in children during their primary school years. It can be used to identify at-risk students. Questions relate to social/emotional abilities, cognitive abilities, movement skills, and other possible characteristics of autism.	Dunn, K. (1998). Adapted from “Asperger’s Syndrome” by Tony Atwood.
Social Skills Checklist	This is a rating scale for students who are in elementary and pre-K. It is a four point scale that addresses: play, understanding emotions, self regulation, flexibility, problem solving, conversation skills, non-verbal skills, and compliments.	Anderson, K. (2013). Adapted from “Supporting Success for Children with Hearing Loss.”
Double Interview from “Thinking about You, Thinking about Me.”	The double interview is designed for school-aged students and is an informal assessment of interactive skills to probe a student’s ability to shift perspective, formulate questions about others, and maintain a topic around another person’s areas of interest. The student’s interaction is evaluated across two contexts: the assessor interviewing the student and the student interviewing the assessor.	Winner, M. G. (2007). Thinking about You, Thinking about Me (2nd ed.). San Jose, CA: Think Social.

ASD EVALUATION TOOLS

<p>Autism Diagnostic Interview-Revised (ADI-R) (Rutter et al. 2003)</p>	<p>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).</p>	<p>Rutter, M., Le Couteur, A., & Lord, C. (2003). Autism diagnostic interview-revised. Los Angeles, CA: Western Psychological Services.</p> <p>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.</p>
<p>Autism Diagnostic Observation Schedule (ADOS) (Lord, Rutter, DiLavore, & Risi, 2002)</p> <p>Revised ADOS 2 Lord, C., Rutter, M., DiLavore, P.C., Risi, S., Gotham, K., & Bishop, S.L. (2012).</p>	<p>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;</p>	<p>Lord, C., Rutter, M., DiLavore, P.C., Risi, S., Gotham, K., & Bishop, S.L. (2012). Autism Diagnostic Observation Schedule 2. Los Angeles, CA: Western Psychological Services.</p>
<p>Childhood Autism Rating Scale, 2nd Edition (CARS-2)</p>	<p>The CARS-2 is for ages 2 and older. This tool helps identify children with autism by providing quantifiable ratings based on direct behavioral observations. There is a High Functioning and a Standard version. The CARS-2 provides information in a variety of areas specific to ASD. For instance, relating to people, verbal and nonverbal communication, body use and adaptation to change are some factors that are measured to create an overall score and assign a severity rating.</p>	<p>Schopler E, Van Bourgondien ME, Wellman, GJ, Love SR (2010). Childhood Autism Rating Scale – 2nd Edition. Los Angeles: Western Psychological Services</p>
<p>Underlying Characteristics Checklist (UCC)</p>	<p>The Underlying Characteristics Checklist is for ages 6 months - adult. It is an informal, non-standardized assessment tool designed to identify characteristics across a number of domains associated with ASD. There are Early Intervention, High Functioning and Classic Versions of this tool. Social, communication, and restricted interests are domains on this tool, in addition to a variety of other domains typically associated with ASD.</p>	<p>Aspy, R., & Grossman, B. G. (2008). The Ziggurat model: A framework for designing comprehensive interventions for individuals with high-functioning autism and Asperger Syndrome (2nd ed.). Shawnee Mission, KS: Autism Asperger Publishing Company.</p>

ASD EVALUATION TOOLS

<p>Checklist for Autism Spectrum Disorder (CASD)</p>	<p>The CASD is for ages 1 – 17, and is a 30 item rating scales for symptoms of autism. It includes problems with social interactions, perseveration, somatosensory disturbance, atypical communication and development, mood, and problems with attention and safety.</p>	<p>Mayes, S. D., & Calhoun, S. L. (1999). Symptoms of autism in young children and correspondence with the DSM. <i>Infants and Young Children</i>, 12, 90–97. Stoelting Co. Publishing Company.</p>
<p>Autism Spectrum Rating Scales</p>	<p>The Autism Spectrum Rating Scales are for ages 2 – 18, completed by parent and/or teacher to evaluate how often they observe specific behaviors in their child or adolescent. Areas include: socialization, communication, unusual behaviors, behavioral rigidity, sensory sensitivity, and self-regulation. It is available in both a long and short form.</p>	<p>Goldstein, S., & Naglieri, J. A. (2010). <i>Autism Spectrum Rating Scales (ASRS): Technical Manual</i>. Toronto, Canada: Multi-Health Systems, Inc.</p>
<p>Monteiro Interview Guidelines for Diagnosis (MIGDAS-2)</p>	<p>The MIGDAS can be used with verbal preschoolers to adults. It provides guidelines for conducting a parent, teacher, and student interview. It contains a pre-interview checklist, parent and teacher interview, and a qualitative student interview.</p>	<p>Monteiro, M. (2008). <i>Monteiro interview guidelines for diagnosing Asperger's Syndrome: A team-based approach</i>. Los Angeles, CA: Western Psychological Services.</p>

TOOLS FOR REPETITIVE BEHAVIORS/RESTRICTED INTEREST AND ASSOCIATED FEATURES

<p>Behavior Rating Inventory of Executive Functions (BRIEF)</p> <p>Preschool Version: Gioia, Espy, & Isquith, 2003; School-Age Version: Gioia, Isquith, Guy, & Kenworthy, 2000)</p>	<p>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-Control 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.</p>	<p>Gioia et al, (2003). <i>BRIEF, BRIEF-P</i>. Los Angeles, CA: Western Psychological Services.</p>
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TOOLS FOR REPETITIVE BEHAVIORS/RESTRICTED INTEREST AND ASSOCIATED FEATURES

Adaptive Behavior Assessment System - 3 (ABAS-3)	This rating scale is for individuals birth - 90 and provides information including: communication, functional academics, self-direction, leisure, social, community use, home-living, health and safety, self-care, and work.	Harrison & Oakland, 2015.
Behavior Assessment System in Children (3rd ed.; BASC-3; Reynolds & Kamphaus, 2015)	The BASC-3 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. (2015). Behavior assessment for children: Third edition.
Barkley Deficits in Executive Functioning Scale: Children & Adolescents (BDEFS-CA)	Barkely offers parent checklists that are empirically based for evaluating clinically significant dimensions of child and adolescent executive functioning. There are 2 parent report forms, both short and long.	Barkley, R. 2012. Barkley Deficits in Executive Functioning Scale. New York, NY. Guilford Press.
Functional Assessment Screening Tool (FAST; LaRue, 2013)	The FAST is a 16-item checklist intended to help identify potential functions or problem behavior. It also includes sections on informant-client relationship. Results can provide an estimate of the potential source of reinforcement.	LaRue R. (2013) Functional Assessment Screening Tool (FAST). In: Volkmar F.R. (eds) Encyclopedia of Autism Spectrum Disorders. Springer, New York, NY. https://doi.org/10.1007/978-1-4419-1698-3_1912
Classroom Observation	N/A	N/A
Functional Behavior Assessment	N/A	N/A
Student or Teacher Interviews	N/A	N/A

Legal Name of Child

DOB

State Child ID (SASID)

Date

Determination of Eligibility: AUTISM SPECTRUM DISORDER

Definition: A child with 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 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.

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 Autism Spectrum Disorder. If the above criteria have been met, the following characteristics should be reviewed by the IEP team for further information about ASD. These characteristics alone will not qualify a child as having 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