

Rutgers Center for Adult Autism Services

Intensive Outpatient Clinic Referral Form

Section I: Patient Information

First Name		Last Name		Date of Birth
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary		Height (ft./in.)		Weight (lbs.)
Street Address		City, State		Zip Is this: <input type="checkbox"/> a personal home <input type="checkbox"/> a residential/ group home

If you selected that the above address is a residential/group home, complete the following:

Company Name		Contact Person Name	Contact Person Title	
Phone Number	Email Address			
Street Address		City, State		Zip

Legal Guardian First Name	Legal Guardian Last Name	Relation to Patient (e.g., parent, sibling, court appointed)		
Street Address		City, State		Zip
Phone Number	Email Address			
Preferred Form of Contact <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Other: _____		Best Time to Reach <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Other: _____		

Has this individual been seen by the Rutgers Center for Adult Autism Services (RCAAS) before?
 Yes No

The following section is only applicable to NJ Residents

Support Coordinator Name	SC Agency	Patient's Current Tier (indicate acuity if applicable)	Program Enrollment <input type="checkbox"/> SP <input type="checkbox"/> CCP
Phone Number		Email Address	
Street Address		City, State	Zip

Primary Care Physician Name (First and Last)		Date of Last Visit	
Office Phone Number	Email Address		
Street Address		City, State	Zip

Person Completing this Form	Relationship to Patient	Date Completing this Form
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Who Referred You to Our Program?

Name (First and Last)		Affiliation	
Phone Number		Email Address	
Street Address		City, State	Zip

Emergency Contact (First and Last)		Relationship to Patient	
Phone Number	Email Address		

Section II: Social History

If the patient currently lives in a personal home, complete the following

Name of Primary Caregiver	This is the patient's <input type="checkbox"/> Biological Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Biological Sibling <input type="checkbox"/> Adoptive Sibling <input type="checkbox"/> Other _____	
How long has the patient lived in this home?	Has the patient ever received residential services before? (this does not include hospitalizations) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	
Please provide a list of individuals who currently live with the patient		
Name	Age	Relationship to Patient

If the patient currently lives in a group home, complete the following

Company Name	How long has the patient lived here?	Is the patient staffed at a ratio of 1:1 or higher? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many other residents live with the patient?	What is the average age of the other residents?	This home is <input type="checkbox"/> Males Only <input type="checkbox"/> Females Only <input type="checkbox"/> Mixed Gender
Has the patient lived in any other residential placements previously? (this does not include hospitalizations) • Yes • No If yes, please list below		
Facility Name	Dates of Residence	Was the patient staffed at a ratio of 1:1 or higher?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Biological/Adoptive Mother's Name	Biological/Adoptive Mother's Age (if deceased, check here <input type="checkbox"/>)
Biological/Adoptive Mother's Occupation	Is the patient's biological/adoptive mother currently active in the patient's care/life? <input type="checkbox"/> Yes <input type="checkbox"/> No
Biological/Adoptive Father's Name	Biological/Adoptive Father's Age (if deceased, check here <input type="checkbox"/>)
Biological/Adoptive Father's Occupation	Is the patient's biological/adoptive father currently active in the patient's care/life? <input type="checkbox"/> Yes <input type="checkbox"/> No
The patient's parents are <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married	

Check any of the following situations the patient is currently experiencing or has previously experienced
<input type="checkbox"/> CPS/Foster Placement <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Caregiver Negligence <input type="checkbox"/> Legal Problems/Arrest <input type="checkbox"/> Other _____
If any of the above were checked, please provide additional detail

Please specify how the patient communicates <input type="checkbox"/> Spoken English <input type="checkbox"/> Spoken Non-English Language (specify _____) <input type="checkbox"/> American Sign Language (ASL) <input type="checkbox"/> Picture Communication System <input type="checkbox"/> Augmentative Communication System (e.g., iPad, Dynavox) <input type="checkbox"/> Other: _____
Please specify the communication level <input type="checkbox"/> Social Conversational <input type="checkbox"/> Answers Questions/ Engages in to-and-fro conversation <input type="checkbox"/> Short Sentences <input type="checkbox"/> 2-3 Word Phrases <input type="checkbox"/> Single Words <input type="checkbox"/> Leading Others Towards Desired Items <input type="checkbox"/> Pointing <input type="checkbox"/> Other: _____

Section III: Medical History and Intervention

Has the patient ever required a surgical procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe below		
Surgery	Date (or age)	Reason
Has the patient experienced a severe head or bodily injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe below		
Please describe the patient's sleeping habits <input type="checkbox"/> No concern <input type="checkbox"/> Regular sleep/wake times <input type="checkbox"/> Irregular sleep/wake times <input type="checkbox"/> Doesn't stay asleep <input type="checkbox"/> Nocturnal Enuresis (nighttime bed wetting) <input type="checkbox"/> Nocturnal Encopresis (nighttime bed soiling) <input type="checkbox"/> Other:		
Please describe the patient's appetite and eating habits <input type="checkbox"/> No concern <input type="checkbox"/> Food selectivity <input type="checkbox"/> Swallowing deficit <input type="checkbox"/> Vomiting <input type="checkbox"/> Packing <input type="checkbox"/> Obesity <input type="checkbox"/> Rumination (bringing back up and/or rechewing partially digested food that has already been swallowed) <input type="checkbox"/> Aerophagia (excessive air swallowing) <input type="checkbox"/> Other:		
Describe the patient's toileting habits <input type="checkbox"/> No concern (independently uses toilet) <input type="checkbox"/> Requires minor assistance in the bathroom, but otherwise, is independent <input type="checkbox"/> Requires pullups/diapers <input type="checkbox"/> Nighttime accidents <input type="checkbox"/> Other:		
Does the patient have any seasonal, food, of medication allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list allergies below		
Does the patient require any special equipment? <input type="checkbox"/> No equipment needed <input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Gait belt <input type="checkbox"/> Leg Braces <input type="checkbox"/> Arm/Hand Splints <input type="checkbox"/> Hearing aid <input type="checkbox"/> Nebulizer <input type="checkbox"/> Oxygen <input type="checkbox"/> Glasses <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Other:		

Please complete the following section regarding psychiatric diagnoses that have been provided by a qualified professional.

<p>Is the patient diagnosed with Intellectual Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please select the severity level</p> <p><input type="checkbox"/> Unsure/Unspecified <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound</p>
<p>Is the patient diagnosed with Autism Spectrum Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is the patient diagnosed with an Anxiety Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe</p>
<p>Is the patient diagnosed with a Mood Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, is the disorder Bipolar I or II Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the disorder is not Bipolar or II Disorder, please describe the disorder</p>
<p>Is the patient diagnosed with a Depressive Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is the patient diagnosed with Obsessive Compulsive Disorder (OCD)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is the patient diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is the patient diagnosed with Post-traumatic Stress Disorder (PTSD)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is the patient diagnosed with Disruptive Behavior Disorder/Conduct Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is the patient diagnosed with Intermittent Explosive Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is the patient diagnosed with Pica? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Please list any other psychiatric diagnoses the patient has received below</p>

<p>Please list any medical diagnoses that have been provided by a qualified professional below</p>

Is the patient currently taking any medication? Yes No
 If yes, complete the following

Medication	Dosage & Administrations Per Day	Prescribing Physician	Reason for Medication	Date Started

Are there any psychiatric medications the patient was previously prescribed? Yes No
 If yes, complete the following

Medication	Dosage & Administrations Per Day	Reason for Medication	Start Date (or Year)	End Date (or Year)

Please complete the following for any specialty services the patient receives			
Specialty	Physician Information	Purpose	Duration of Services
Primary Care Physician (PCP)	Name: Address: Phone Number:		Patient Since _____
Psychiatrist	Name: Address: Phone Number:		Patient Since _____
Speech Therapist	Name: Address: Phone Number:		Patient Since _____
Occupational Therapist	Name: Address: Phone Number:		Patient Since _____
Physical Therapist	Name: Address: Phone Number:		Patient Since _____
ABA Therapist	Name: Address: Phone Number:		Patient Since _____
Other _____	Name: Address: Phone Number:		Patient Since _____

Section IV: Family History

Please check any of the following conditions that are or have been present in the patient's immediate or extended biological family					
	Sibling	Mother	Father	Mother's Relatives	Father's Relatives
Developmental Delay					
ADHD					
Intellectual Disability					
Learning Disability					
Cerebral Palsy					
Blindness					
Deafness					
Seizures					
Autism					
Tics/Tourette's					
Depression					
Anxiety					
Suicide					
OCD					
Schizophrenia					
Sleep Disorder					
Alcohol Abuse					
Drug Abuse					
Migraine Headaches					
High Blood Pressure					
Diabetes					
Obesity					
Cancer					
Dementia/Alzheimer's					
Genetic Disorder					

Section V: Educational & Employment History

<p>What type of school placement did the patient receive immediately prior to entering adulthood (age of 21)?</p> <p> <input type="checkbox"/> No school placement <input type="checkbox"/> Home School <input type="checkbox"/> Public School <input type="checkbox"/> Private School </p>			
<p>Please list the schools attended below starting with the most recent school.</p>			
Name of School Placement	Location	Years attended	
<p>While in school, which special services, if any, did the patient require?</p> <p> <input type="checkbox"/> No services <input type="checkbox"/> Mainstreamed class <input type="checkbox"/> Individualized Education Plan (IEP) </p> <p> <input type="checkbox"/> Behavior Intervention Plan (BIP) <input type="checkbox"/> Specialized Classroom for Problem Behavior </p> <p> <input type="checkbox"/> Staffing ratio of 1:1 or greater <input type="checkbox"/> Vision <input type="checkbox"/> Speech/Language <input type="checkbox"/> Occupational Therapy </p> <p> <input type="checkbox"/> Other: </p>			
<p>Did the patient attend any higher education institution after high school? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate the name and location of the institution(s):</p>			
<p>Is the patient currently, or has ever been, employed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list all places of employment starting with the most recent job held.</p>			
Employer	Location	Job Title	Dates of Employment

Does the patient currently attend a day habilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, complete the following:		
Day Habilitation Company Name	Contact Person Name	Contact Person Title
Phone Number	Email Address	
Street Address	City, State	Zip

Does the patient currently receive prevocational or vocational training outside of the context of a day habilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, complete the following:		
Company Name	Contact Person Name	Contact Person Title
Phone Number	Email Address	
Street Address	City, State	Zip

Does the patient currently receive other day services not previously mentioned? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, complete the following:		
What is the service provided?		
Service Provider Name	Contact Person Name	Contact Person Title
Phone Number	Email Address	
Street Address	City, State	Zip

Section VI: Behavioral Concerns and Intervention

<p>Does the patient engage in self-injurious behavior (SIB)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, skip to the next box (regarding pica).</p> <p>If yes, please indicate which of the following the patient engages in.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Head-banging</td> <td><input type="checkbox"/> Hand-to-head hitting</td> <td><input type="checkbox"/> Wrist to surface</td> </tr> <tr> <td><input type="checkbox"/> Pulling own hair</td> <td><input type="checkbox"/> Biting self</td> <td><input type="checkbox"/> Skin picking</td> </tr> <tr> <td><input type="checkbox"/> Eye poking</td> <td><input type="checkbox"/> Body hitting</td> <td><input type="checkbox"/> Self-scratching</td> </tr> <tr> <td><input type="checkbox"/> Self-pinching</td> <td><input type="checkbox"/> Rectal digging</td> <td><input type="checkbox"/> Nose picking</td> </tr> <tr> <td><input type="checkbox"/> Chin pressing on object</td> <td><input type="checkbox"/> Ear pulling</td> <td><input type="checkbox"/> Self-kicking</td> </tr> <tr> <td><input type="checkbox"/> Mouth biting</td> <td><input type="checkbox"/> Object to head</td> <td><input type="checkbox"/> Object to body</td> </tr> <tr> <td><input type="checkbox"/> Body slamming on wall</td> <td><input type="checkbox"/> Joint popping</td> <td><input type="checkbox"/> Teeth grinding</td> </tr> <tr> <td><input type="checkbox"/> Coprophagia (ingesting feces)</td> <td><input type="checkbox"/> Other:</td> <td><input type="checkbox"/> Other:</td> </tr> </table>	<input type="checkbox"/> Head-banging	<input type="checkbox"/> Hand-to-head hitting	<input type="checkbox"/> Wrist to surface	<input type="checkbox"/> Pulling own hair	<input type="checkbox"/> Biting self	<input type="checkbox"/> Skin picking	<input type="checkbox"/> Eye poking	<input type="checkbox"/> Body hitting	<input type="checkbox"/> Self-scratching	<input type="checkbox"/> Self-pinching	<input type="checkbox"/> Rectal digging	<input type="checkbox"/> Nose picking	<input type="checkbox"/> Chin pressing on object	<input type="checkbox"/> Ear pulling	<input type="checkbox"/> Self-kicking	<input type="checkbox"/> Mouth biting	<input type="checkbox"/> Object to head	<input type="checkbox"/> Object to body	<input type="checkbox"/> Body slamming on wall	<input type="checkbox"/> Joint popping	<input type="checkbox"/> Teeth grinding	<input type="checkbox"/> Coprophagia (ingesting feces)	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
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<input type="checkbox"/> Coprophagia (ingesting feces)	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:																						
<p>Does the patient wear any protective equipment due to their self-injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the relevant equipment worn by the patient.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Helmet</td> <td><input type="checkbox"/> Arm splints</td> <td><input type="checkbox"/> Knee pads</td> </tr> <tr> <td><input type="checkbox"/> Gloves</td> <td><input type="checkbox"/> Other:</td> <td><input type="checkbox"/> Other:</td> </tr> </table>	<input type="checkbox"/> Helmet	<input type="checkbox"/> Arm splints	<input type="checkbox"/> Knee pads	<input type="checkbox"/> Gloves	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:																		
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<input type="checkbox"/> Gloves	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:																						
<p>How often does the patient engage in self-injurious behavior?</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> Daily <input type="checkbox"/> Hourly <input type="checkbox"/> Multiple times per hour</p>																								
<p>Please rate the severity of the self-injurious behavior by selecting one of the following</p> <p><input type="checkbox"/> Self-injurious behavior does not result in visible marks on the body and does not consist of any blows close to or contacting the eyes</p> <p><input type="checkbox"/> Self-injurious behavior occasionally results in reddening of the skin and/or mild swelling</p> <p><input type="checkbox"/> Self-injurious behavior frequently results in light scratches, small or shallow breaks in the skin and/or moderate to severe swelling AND/OR self-injurious behavior that occasionally leaves a scar</p> <p><input type="checkbox"/> Self-injurious behavior frequently results in scratches or other breaks to the skin that leaves scars AND/OR SIB either frequently or occasionally involves blows close to or contacting the eyes or results in trauma involving broken bones or lasting tissue damage or disfigurement</p>																								
<p>Does the patient engage in pica (attempting to or successfully eating inedible objects)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, skip to the next box (regarding aggression).</p> <p>If yes, please describe items that are typically targeted for consumption or have been targeted in the past:</p>																								
<p>How often does the patient engage in pica?</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> Daily <input type="checkbox"/> Hourly <input type="checkbox"/> Multiple times per hour</p>																								

Please rate the severity of pica by selecting one of the following

- Pica does NOT involve any of the following: solid items larger than ½ inch in diameter (e.g., coins, large buttons), sharp items (e.g., pins, staples), contaminated items (e.g., items from garbage can or ash tray, paint chips), or toxic/poisonous items (e.g., medicines, glue)
- Pica involves solid items larger than ½ inch in diameter (e.g., coins, large buttons), but not sharp, contaminated, or toxic or poisonous items
- Pica involves sharp, contaminated, or toxic or poisonous items, but not requiring emergency medical attention (e.g., called physician for advice)
- Pica involves sharp, contaminated, or toxic or poisonous items requiring emergency medical attention

Does the patient engage in **aggressive behavior**? Yes No

If no, skip to the next box (regarding property destruction).

If yes, please indicate which of the following the patient engages in.

- | | | |
|---|---|--|
| <input type="checkbox"/> Hitting others | <input type="checkbox"/> Kicking others | <input type="checkbox"/> Biting others |
| <input type="checkbox"/> Punching | <input type="checkbox"/> Grabbing | <input type="checkbox"/> Hair pulling |
| <input type="checkbox"/> Pinching | <input type="checkbox"/> Head butting | <input type="checkbox"/> Slapping |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Pushing/shoving | <input type="checkbox"/> Choking |
| <input type="checkbox"/> Throwing objects at others | <input type="checkbox"/> Spitting at others | <input type="checkbox"/> Chin pressing on others |
| <input type="checkbox"/> Body slamming | <input type="checkbox"/> Pulling on others | <input type="checkbox"/> Twisting fingers |
| <input type="checkbox"/> Limb twisting | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

How often does the patient engage in aggressive behavior?

- Monthly Weekly 2-3 times per week Daily Hourly Multiple times per hour

Please rate the severity of the aggressive behavior by selecting one of the following

- Aggressive behavior does not result in any marks to other's bodies and does not involve blows close to or contacting the eyes
- Aggressive behavior occasionally results in reddening of the skin and/or mild swelling
- Aggressive behavior frequently results in light scratches, small or shallow breaks in the skin and/or moderate to severe swelling AND/OR aggressive behavior that occasionally results in scars
- Aggressive behavior fluently results in scratches or other breaks to the skin that leave scars AND/OR aggressive behavior either frequently or occasionally involves blows close to or contacting the eyes or results in trauma involving broken bones or lasting tissue damage or disfigurement

Does the patient engage in **property destruction**? Yes No
 If no, skip to the next box (regarding disruptive behavior).

If yes, please indicate which of the following the patient engages in.

<input type="checkbox"/> Throwing objects	<input type="checkbox"/> Tearing objects	<input type="checkbox"/> Kicking objects
<input type="checkbox"/> Swiping objects	<input type="checkbox"/> Breaking objects	<input type="checkbox"/> Knocking over furniture
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

How often does the patient engage in property destruction?

Monthly Weekly 2-3 times per week Daily Hourly Multiple times per hour

Please rate the severity of the property destruction by selecting one of the following

Property destruction results in disruption of the property but no permanent damage to paper items, plastic items, electronics, furniture, vehicles, or buildings

Property destruction occasionally results in damage to paper items or other light objects

Property destruction frequently results in breaking pencils, plastic items, electronics, or other breakable items and/or scratches or permanent marks on furniture, walls, cars, etc., AND/OR occasionally results in structural damage

Property destruction frequently results in structural damage to furniture, cars, walls, etc.

Does the patient engage in **disruptive behavior**? Yes No
 If no, skip to the next box (regarding non-compliance).

If yes, please indicate which of the following the patient engages in.

<input type="checkbox"/> Banging on objects	<input type="checkbox"/> Screaming	<input type="checkbox"/> Stomping feet
<input type="checkbox"/> Playing with saliva	<input type="checkbox"/> Spitting on objects	<input type="checkbox"/> Fecal smearing
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

How often does the patient engage in disruptive behavior?

Monthly Weekly 2-3 times per week Daily Hourly Multiple times per hour

Please rate the severity of the disruptive behavior by selecting one of the following

Disruptive behavior does not interfere with daily activities and the patient can participate fully. Disruptive behaviors occur across less than 25% of waking hours. Minor environmental manipulations are required to avoid disruptions and redirection of these behaviors is easy.

Disruptive behaviors interfere with daily activities such that the patient's participation is limited some of the time (i.e., trips are avoided or are not possible due to high levels of behaviors). Disruptive behaviors occur across more than 25-50% of waking hours. Environmental manipulations are required to avoid disruptions and redirection of these behaviors is manageable.

- Disruptive behaviors interfere with daily activities such that the patient's participation is limited most of the time (i.e., trips are avoided or are not possible due to high levels of behaviors). Disruptive behaviors occur across more than 50-75% of waking hours. Moderate environmental manipulations are required to avoid disruptions and redirection of these behaviors is difficult, but possible.
- Disruptive behaviors interfere with daily activities such that the patient cannot participate fully (i.e., trips are avoided or are not possible due to high levels of behaviors). Disruptive behaviors occur across more than 75% of waking hours. Significant environmental manipulations are required to avoid disruptions and redirection of these behaviors is difficult.

Does the patient engage in **non-compliance**? Yes No

If no, skip to the next box (regarding elopement).

If yes, please indicate which of the following the patient engages in.

- | | | |
|--|---|---|
| <input type="checkbox"/> Saying "No" | <input type="checkbox"/> Whining/crying | <input type="checkbox"/> Refusal to complete task |
| <input type="checkbox"/> Engaging in SIB | <input type="checkbox"/> Becomes aggressive | <input type="checkbox"/> Becomes disruptive |
| <input type="checkbox"/> Drops to floor | <input type="checkbox"/> Slides to floor | <input type="checkbox"/> Refuses to remain seated |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

How often does the patient engage in non-compliance?

- Monthly Weekly 2-3 times per week Daily Hourly Multiple times per hour

Please rate the severity of the non-compliance by selecting one of the following

- When presented with an instruction, non-compliance frequently occurs and consists of refusing to do the task or whining
- When presented with an instruction, non-compliance frequently occurs and consists of crying, or sliding/dropping to the floor AND/OR non-compliance occasionally occurs and consists of disruptive behavior or property destruction
- When presented with an instruction, non-compliance frequently occurs and consists of disruptive behavior or property destruction AND/OR non-compliance occasionally occurs and consists of aggressive or self-injurious behavior
- When presented with an instruction, non-compliance frequently occurs and consists of aggressive or self-injurious behavior

Does the patient engage in **elopement**? Yes No

If no, skip to the next box (regarding dangerous behaviors).

If yes, please indicate which of the following the patient engages in.

- Attempts to leave a confined area (e.g., room, house, etc.)
- Refuses to remain seated (e.g., wanders away during meals or stationary vocational work)
- Attempts to pull away from you/staff / run away in public
- Other:

How often does the patient engage in elopement?

- Monthly Weekly 2-3 times per week Daily Hourly Multiple times per hour

Please rate the severity of the elopement by selecting one of the following

- Elopement involves slowly wandering away from caregivers and/or refusing to remain seated within a single room
- Elopement involves wandering away from caregivers to go to another room (within the same building)
- Elopement involves pulling away from caregivers and attempting to (or successfully) leaving the caregiver in public, but is easy to retrieve
- Elopement involves attempting to (or successfully) darting away from caregivers either in public or leaves a confined building and is difficult to retrieve/requires law enforcement to locate

Does the patient engage in **dangerous behaviors**? Yes No

If no, skip to the next box (regarding emesis and ruminations).

If yes, please indicate which of the following the patient engages in.

- | | | |
|--|---|--|
| <input type="checkbox"/> Climbing on furniture | <input type="checkbox"/> Jumping on/off furniture | <input type="checkbox"/> Tipping furniture |
| <input type="checkbox"/> Standing on furniture | <input type="checkbox"/> Touching heating vents | <input type="checkbox"/> Touching stoves |
| <input type="checkbox"/> Touching electrical sockets | <input type="checkbox"/> Banging on windows | <input type="checkbox"/> Climbing on windowsills |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

How often does the patient engage in dangerous behaviors?

- Monthly Weekly 2-3 times per week Daily Hourly Multiple times per hour

Please rate the severity of the dangerous behaviors by selecting one of the following

- Dangerous behavior does NOT result in marks on the body or broken property
- Dangerous behavior occasionally results in reddening of skin, mild swelling, first-degree burns, or damage to property that is easily repaired
- Dangerous behavior frequently results in light scratches, small or shallow breaks in the skin, moderate to severe swelling, a second-degree burn, or damage to property that is difficult to repair
- Dangerous behavior results in scars, lasting tissue damage, disfigurement, a third-degree burn, or damage to property that is not possible to repair

Does the patient engage in **emesis and/or rumination**? Yes No

If no, skip to the next box (regarding ritualistic behavior).

If yes, please indicate which of the following the patient engages in.

- Emesis (vomiting)

<input type="checkbox"/> Rumination (bringing back up and/or re-chewing partially digested food that has already been swallowed) <input type="checkbox"/> Other:
How often does the patient engage in emesis and/or rumination? <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> Daily <input type="checkbox"/> Hourly <input type="checkbox"/> Multiple times per hour
Please rate the severity of the emesis and/or rumination by selecting one of the following <input type="checkbox"/> The patient engages in mild gagging behavior <input type="checkbox"/> The patient occasionally engages in rumination and/or emesis that does NOT damage the esophagus, teeth, gums, or mouth <input type="checkbox"/> The patient frequently engages in rumination and/or emesis that does damage the esophagus, teeth, gums, and/or mouth but does NOT lead to malnourishment, loss of consciousness, or hospitalization <input type="checkbox"/> He patient frequently engages in rumination and/or emesis that does damage the esophagus, teeth, gums, and/or mouth AND has led to malnourishment (and/or need for a feeding tube), loss of consciousness, or hospitalization

Does the patient engage in ritualistic behavior ? (Rigid routines that, when interrupted or unable to complete, can lead to challenging behavior) <input type="checkbox"/> Yes <input type="checkbox"/> No If no, skip to the next section. If yes, please describe some rituals that are particularly problematic.
How often does the patient engage in ritualistic behavior? <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> Daily <input type="checkbox"/> Hourly <input type="checkbox"/> Multiple times per hour
Please rate the severity of the ritualistic behavior by selecting one of the following <input type="checkbox"/> When presented with a disruption to a ritual, the patient may whine, cry, or vocally protest <input type="checkbox"/> When presented with a disruption to a ritual, the patient frequently non-violently pushes caregivers or other out of the way AND/OR occasionally engages in disruptive behavior or property destruction <input type="checkbox"/> When presented with a disruption to a ritual, the patient frequently engages in disruptive behavior or property destruction AND/OR occasionally engages in aggressive or self-injurious behavior that leads to minor injuries <input type="checkbox"/> When presented with a disruption to a ritual, the patient frequently engages in aggressive or self-injurious behavior that leads to moderate-severe injuries

Please note any other problem behaviors the patient engages in below.

Have the patient's problem behaviors resulted in any of the following?

- Breaks to the skin leaving scars, broken bones, or lasting tissue damage to the patient
- Breaks to the skin leaving scars, broken bones, or lasting tissue damage to others
- Blows directed to own head resulting in concussions or other head trauma
- Blows directed towards others resulting in concussions or other head trauma
- Blows close to or contacting own eyes
- Blows close to or contacting other's eyes
- Emergency department visit by the patient
- Emergency department visit by others (e.g., after aggressive behavior)
- Hospitalization (e.g., on a psychiatric or neurobehavioral unit)
- Placement in a developmental center
- Involvement of law enforcement
- Consumption of sharp, contaminated, or toxic items
- Structural damage to furniture, walls, cars, etc.
- Running away from caregivers, out of sights, and difficult to retrieve
- None of the above

Does the patient currently have a Behavior Support Plan (BSP) in place?

- Yes No

*If yes, please send a copy of the BSP along with this form.

Section VII: Admission Information

Does the patient receive Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to the next box)	
State of Medicaid Program	Phone Number
Medicaid Member ID Number	
*For residence of New Jersey, is the patient approved to participate in the NJ DDD Supports Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does the patient receive private health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to the next box)			
Insurance Company		Contact Number for the Plan	
Policy Holder's Name	Policy Holder's DOB	Policy ID Number	Policy Group Number
Policy Holder's Phone Number		Policy Holder's Address	

<p>If admitted into the Intensive Outpatient Clinic, will the caregiver or other provider be able to provide transport to and from the Rutgers Center for Adult Autism Services?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Thank you for completing this form! Once you are finished, please submit this document (along with a current copy of the patient's Behavior Support Plan, if applicable) to ioc-referrals@rcaas.rutgers.edu.