

EI Case Presentation

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Record ID

1

ECHO Autism Early Intervention

Ages 0-8 Years

Case Presentation Form

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Complete this form to the best of your ability. This survey is individualized and should only be completed and submitted by the listed provider. A unique confidential patient ID number (ECHO ID) has been provided that must be utilized when identifying your patient during clinic.

Email our clinic coordinator **Sarah Towne** at sarahtowne@health.missouri.edu if you have any questions or comments.

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any UMH clinician and any patient whose case is being presented in a Project ECHO setting.

Presenting Provider Name:

ECHO ID:

Clinic/Facility:

Provider Phone Number:

Provider Fax Number:

Presentation date:

M-D-Y

Patient Data

Biological Gender:

Male Female Unsure

Patient Age:

1

4

Insurance:

Medicaid ▾

Insurance Company:

Race:

White/Caucasian ▾

Ethnicity:

Not Hispanic/Latino ▾

Patient Outcomes

Who referred the child to you?

Therapy provider ▾

How long has the child been in your care?

13 months

Has the patient received a diagnosis?

No ▾

How long did the patient have to wait to see you?

Less than 1 month

How long has the patient been in your care?

13 months

Is the patient in individual or group intervention?

Individual ▾

How often do you see the patient?

Weekly

How many sessions have you had with the patient?

200

Who typically accompanies the patient to clinic appointments?

Mother

How far did the patient travel to get to you office?

Miles:

Services provided in the home

Hours:

Minutes:

List the questions you would like help with.

1)

Brother was diagnosed in May 2023 level 3 ASD. Little sister is showing many symptoms brother did. Is it possible to get evaluated early? The same provider that diagnosed brother states insurance will not pay for diagnosis under age 3.

2)

What EBP and services are recommended for encouraging social reciprocity and shared interest as well as communication in this young of a child?

Family is concerned behaviors will escalate as they did with brother, want to intervene earlier.

3)

Where do we focus services with the limited services available?

Birth History

Exposures during pregnancy:

Smoking Alcohol Valproic Acid Street drugs/other Unknown

Other:

Mother had gestational diabetes, on seizure med, and med for depression during pregnancy.

Gestational age:

37 weeks

(weeks)

Birth weight:

8 lbs

(lbs)

7

(oz)

Delivery mode:

Vaginal C-section

If C-section, why?

Gestational diabetes, bed rest most of third trimester, heart rate dropped

Presentation:

Breech Head first

Were there newborn problems?

Yes No

If yes, explain:

Struggled with feeding and weight gain. NICU 6 weeks

Please check all of the following that apply:

- In NICU
- Required intubation
- Seizures
- Birth defects
- Feeding issues in infancy
- Other

Comments:

Referred to First Steps, qualified for pediatric feeding disorder, feeding aversion, re admission to hospital for G tube placement. First Steps services for feeding therapy, dietitian services and added PT at 5 months for gross motor delays.

Development History

Communication Ability (Please indicate the child's highest communication/s)

- Nonverbal (e.g., no functional words)
- Uses single words
- Uses 2-3 word phrases
- Uses sentences
- Chats with other
- Uses gestures (e.g., pointing, waving and/or leads other to wants/needs)

Behavior Concerns

- Short attention span
- Hyperactivity
- Obsessive-compulsive
- Aggressive
- Hurting animals or other people
- Unusual or excessive fears
- Depression
- Defiant
- Self-injury (e.g., head banging, biting, scratching, cutting, picking, etc.)
- Toileting issues, accidents
- Irritability/Moodiness
- Hallucinations

Comments:

Medical/Psychiatric History

Please list all diagnosis, surgeries, illnesses and or any significant medical history:

Diagnosis/Illness:

Feeding aversion, pediatric feeding disorder, G-tube placement

Age:

3 months

Date - Year:

8/2022

Professional making diagnosis:

McKenzie Smith

Diagnosis/Illness:

Please list current medications and supplements:

Medication:

Please check all of the following that apply:

- Seizures
- Tic Disorder
- Staring spells
- Toe walking
- Hypertonia
- Hypotonia
- Microcephaly
- Macrocephaly
- Chronic stomach ache/pain/reflux
- Chronic constipation
- Chronic diarrhea
- Chronic ear infections
- Food allergy
- Environmental allergies
- Skin problems (e.g., rash, eczema)

Comments:

Milk allergy, constipation resolved after eliminating milk

Testing

Have the following tests been performed?

Chromosomal Microarray

Yes No Unknown

Results:

Waiting for results

Karyotype

Yes No Unknown

Fragile X DNA

Yes No Unknown

MRI of the brain

Yes No Unknown

EEG

Yes No Unknown

Sleep study

Yes No Unknown

Lead blood level

Yes No Unknown

Audiologic (hearing) exam

Yes No Unknown

Results:

Screening passed

Vision screening

Yes No Unknown

Results:

Screening passed

Academic testing

Yes No Unknown

Intelligence testing

Yes No Unknown

Comments:

DAYC August 2022

Dietary/Nutrition/Metabolic

Please check all of the following that apply:

- Problem eater (Less than 10 foods)
- Picky eater (Less than 20 foods)
- Special Diet
- Pica (Eating/craving non-food items)
- Chewing or swallowing issues
- History of growth concerns - Overweight
- History of growth concerns - Underweight

Which beverages does the child drink regularly?

- Water Milk Juice/Sweetened beverages

Comments:

Limited coconut milk and Kate farms formula via G-tube

Sleep History

Rarely = never or 1 time/week; **Sometimes** = 2-4 times/week; **Usually** = 5 or more times/week

Does the child fall asleep within 20 minutes? If yes, how often?

- No Rarely Sometimes Usually Unsure

Does the child awaken more than once during the night? If yes, how often?

- No Rarely Sometimes Usually Unsure

Is this a problem?

No

Comments:

Trauma/Abuse History

	No	Yes	Suspected
Trauma/Abuse History	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Abuse	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual Abuse	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments:

Social History

Child resides with:

Has legal custody of the child:

Biological parents are:

How many people live in the home *not* including the child?

Who lives in the home with the child?

Relationship (1/2 sib, step-parent, etc.):

Age:
(yrs) (mos)

Gender:

Relationship:

Age:
(yrs) (mos)

Gender:

Relationship:

Age:
(yrs) (mos)

Gender:

List other significant caregivers that live outside the home (e.g., family, friends, grandparents, neighbor):

Elderly grandparents help with brother at times

Comments:

Family History

Condition/Disorder

	Mom	Dad	Brother	Sister
Genetic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder (e.g., epilepsy)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Concerns (e.g., Depression, Anxiety Disorder, Bipolar)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood deaths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysmorphology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Child Care or Educational History

What is the child's current child care or educational placement? (Please check all that apply)

- Parents provide full time child care at home
- In-home child care (other caregiver)
- In-home day care
- Day care center
- Preschool
- Head Start or Early Head Start
- Homeschool
- 1st Steps
- Public School
- Private School

Does the child participate in either of the following?

- Early Intervention Services (First Steps or Birth-3 Program) Early Childhood Special Education (ECSE)

If the child attends child care or school outside the home, what is the typical schedule?

- Full Day Part Day

Does the child have an IEP or 504 plan?

- Yes No

Comments:

IFSP First Steps

Outside Resources

Resources:

- Bureau of Special Health Care Needs
- Behavioral Therapy/ABA
- Easter Seals
- Division of Family Services (DFS)
- Physical Therapy (PT)
- Parents as Teachers (PAT)
- WIC
- Counseling
- Regional Center (Dept. of Mental Health)
- Speech Language Therapy (SLT)
- Psychiatric Services
- First Steps
- Occupational Therapy (OT)
- Social Security Disability (SSI)
- None of the above
- Other

Other resource/s:

Dietician

Is Physical Therapy provided in an outpatient or school setting?

- Outpatient
 School Setting
 Both

Is Occupational Therapy provided in an outpatient or school setting?

- Outpatient
 School Setting
 Both

Comments

Family centered Services provided in the home

Social Communication

A1. Deficits in social-emotional reciprocity. (Click all that apply)

- Unusual social initiations (e.g., intrusive touching, licking or others)
- Use of others as tools (e.g. child uses your hand to initiate a task)
- Failure to respond when name called or when spoken directly to
- Does not initiate conversations
- Lack of showing or pointing out objects of interest to other people
- Lack of responsive social smile
- Failure to share enjoyment, excitement or achievements with others
- Does not show pleasure in social interactions
- Failure to offer comfort to others
- Only initiates to get help

A2. Deficits in nonverbal communicative behaviors used for social interaction (check all that apply)

- Impairments in social use of eye contact
- Impairment in the use and understanding of body postures (e.g. facing away from listener)
- Impairment in the use and understanding of gestures (e.g. pointing, waving, nodding head)
- Abnormal volume, pitch, intonation, rate, rhythm, stress, prosody or volume in speech
- Lack of coordinated verbal and nonverbal communication (e.g. inability to coordinate eye contact or body language with words)

A3. Deficits in developing, maintaining, and understanding relationships

- Inability to take another person's perspective (4 years or older)
- Does not notice another person's lack of interest in an activity
- Lack of response to contextual cues (e.g. social cues from others indicating a change in behavior is implicitly requested)
- Inappropriate expressions of emotion (laughing or smiling out of context)
- Lack of imaginative play with peers
- Does not try to establish friendships
- Lack of cooperative play (over 24 months of age)
- Lack of interest in peers
- Withdrawn; aloof; in own world
- Prefers solitary activities

Restricted/Repetitive Behavior

B1. Stereotyped or repetitive motor movements, use of objects, or speech

- Lining up toys
- Nonfunctional play with objects (Examples: dropping items repetitively, holding objects for long periods of time without purpose)
- Repetitively turns on/off lights
- Echolalia
- Idiosyncratic phrases (Example: "crunchy water" for ice)
- Hand flapping
- Rocking
- Flicking fingers in front of eyes
- Opening/closing doors
- Spinning
- Unusually formal language (Example: little professor talk)
- Jargon or gibberish past developmental age of 24 months
- Use of "rote" language
- Pronoun reversal and/or refers to self by own name
- Repetitive vocalizations (Examples: unusual squealing, repetitive humming)
- Abnormal posture (Examples: toe walking, intense full body posturing)

- Excessive teeth grinding
- Repetitive picking

B2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior

- Difficulty with transition
- Unusual routines
- Repetitive questioning about a particular topic
- Extreme distress with small changes
- Rigid thinking patterns (Examples: inability to understand humor or nonliteral aspects of speech such as irony)
- Greeting rituals or other verbal rituals
- Compulsions (Example: must turn in a circle three times before entering a room)
- Need to take some route or eat same food every day

B3. Highly restricted, fixated interests that are abnormal in intensity or focus

- Strong attachment to or preoccupation with unusual objects (Examples: fans, elevators)
- Excessively circumscribed or perseverative interests (Examples: dinosaurs, alphabet, shapes)
- Being overly perfectionistic
- Excessive focus on nonrelevant or nonfunctional parts of objects (Example: overly focused on wheels on car)
- Attachment to unusual inanimate object (Example: measuring cup or ring from canning jar)
- Unusual fears (Example: people wearing earrings or hats)

B4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment

- Apparent indifference to pain/temperature
- Adverse response to specific sounds or textures (Examples: tactile defensiveness, significant aversion to nail cutting)
- Excessive smelling, licking or touching of objects
- Visual fascination with lights or movement (Examples: close visual inspection of objects or self for no clear purpose)
- Excessive movement, seeking behavior

Additional Comments

Restricted interest in toys or playing with others. Avoids interactions with others, Repetitive motor movements such as flapping or clapping hands, rotating wrists and ankles, bounces legs, avoids standing on flat feet. Starting to see loss of words.

Proposed Recommendations:

Based on my assessment, the following recommendations are proposed for the child:

1)

2)

3)

4)

5)

6)

Form Status

Complete?

Complete ▼