ADX CASE Form

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ECHO Autism: Advanced Diagnosis 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 clinician. A unique confidential patient ID number (ECHO ID) has been provided that must be utilized when identifying your patient during clinic.

Email our program coordinator **Michael Hansen** at michaelhansen@health.missouri.edu if you have any questions or comments.

PLEASE NOTE: Project ECHO de-identified case discussions do not create or otherwise establish a clinician-patient relationship between any University of Missouri Health Care clinician and any patient whose case is being discussed in a Project ECHO setting. All information is deidentified and the participants and content experts are engaged in case-based learning.

Clinician Information

Presenting Clinician Name: Mirae Fornander

Clinic/Facility Name: Pediatric Associates **City:** Kansas City

ECHO ID: DX108

Presentation Date: 01-10-2024 M-D-Y

Presentation Type: (●) New ( ) Follow Up

Patient Information

Sex assigned at birth:

( ) Male (●) Female

Gender patient identifies with:

○ Male ◉ Female ○ Non-binary ○ Other ○ Prefer not to respond

Patient Age: 17 10

Race:

- ☐ Multiracial
- ☑ White/Caucasian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Prefer not to say
- ☐ Other

Ethnicity:

- ○ Hispanic/Latino or Spanish Origin
- ◉ Not Hispanic/Latino or Spanish Origin
- ○ Prefer not to say

Insurance:

- ☐ None
- ☐ Medicaid
- ☑ Private

Insurance Company:

Patient Outcomes

Is this patient an existing patient or a new patient?

◉ Existing patient
○ New patient

How long has the individual been in your care? 01/18/2023

Who referred the individual to you (ECHO Autism Clinician)? Physician/practitioner

Please specify:

◉ In your practice
○ Outside your practice

Do you know if the person who referred this patient to you are also part of ECHO Autism Communities?

○ Yes
◉ No
○ I Don't Know

Is this patient currently on another waitlist for a diagnostic evaluation?

○ Yes
◉ No
○ I Don't Know

How long did the patient wait to see you, the ECHO Autism Clinician, to START their autism assessment?

How long did it take you to complete your assessment?

Estimate the total time between receipt of referral to when you will give/gave family diagnosis?

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

Miles 15

Approximately, how long does it take the patient to drive to your office?

Hours: Hours

Minutes 30

List the questions you would like help with.

1)

Given her complex history and age is pushing for an ASD eval beneficial for the family, especially given their financial barriers and parent lack of interest in identifying a "diagnosis?"

2)

What would you prioritize in treatment at this point?

3)

Any referrals that would be helpful?

Birth History

Exposures during pregnancy:

☐ Smoking ☐ Alcohol ☐ Valproic Acid ☐ Street drugs ☐ Other ☐ Unknown

Gestational age: Weeks

Birth weight: lbs

oz

Delivery mode:

(•) Vaginal ( ) C-section

Presentation:

( ) Breech ( ) Head first

Head circumference: Inches

Were there newborn problems?

( ) Yes (•) No ( ) Unsure

Please check all of the following that apply:

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

Comments:

Development History

Please indicate the age (in months) when milestone was achieved.
If unknown, please type unknown.

Uses single words:

Uses 2-3 word phrases:

Speak in full sentences:

Walking:

Daytime bladder control:

Nighttime bladder control:

Bowel control:

Social smile:

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

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

Behavior Concerns

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

Please check all that apply

Do parents share your concern about autism?

- ○ Yes
- ◉ No

Has there been significant loss of an acquired skill or skills?

- ○ Yes
- ○ No

Comments:

Medical/Psychiatric History

Please list all diagnoses or illnesses:

Diagnosis/Illness: 315.1 (F81.2) Specific Learning Disorder, with ir

Age: 17

Date - Year:	2023
Professional making diagnosis:	Psychologist
Diagnosis/Illness:	300.00 (F41.9) Unspecified Anxiety Disorder, by
Age:	15
Date - Year:	2021
Professional making diagnosis:	Pediatrician
Diagnosis/Illness:	296.30 (F33.9) Major Depressive Disorder, Recu
Age:	15
Date - Year:	2021
Professional making diagnosis:	Pediatrician
Diagnosis/Illness:	307.50 (FS0.9) Unspecified Feeding or Eating Di
Age:	15
Date - Year:	2021
Professional making diagnosis:	Pediatrician
Diagnosis/Illness:	

Please list current medications and supplements:

Medication:	Sertraline
Dosage:	75 mg
Age when started:	17
Reason for medication:	Anxiety and Depression
Is it helping?	(•) Yes ( ) No

Medication:

Additional Conditions

Please check all of the following that apply:

- [ ] Seizures
- [ ] Tic Disorder
- [ ] Staring spells
- [x] 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:

Medical Testing

Have the following medical tests been performed?

Vision screening

- (•) Yes ( ) No ( ) Unknown

Results:

Audiologic (hearing) screening

- (•) Yes ( ) No ( ) Unknown

Results:

Lead blood level

- ( ) Yes (•) No ( ) Unknown

Chromosomal Microarray

- ( ) Yes (•) No ( ) Unknown

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

Comments:

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

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

Does the child co-sleep? If yes, how often?

◉ No ○ Rarely ○ Sometimes ○ Usually

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

◉ No ○ Rarely ○ Sometimes ○ Usually

Does the child snore loudly?

(•) No ( ) Rarely ( ) Sometimes ( ) Usually

Does the child seem tired during the day? If so, how often?

( ) No ( ) Rarely (•) Sometimes ( ) Usually

Is this a problem?

( ) Yes (•) No

Comments:

Trauma/Abuse History

	No	Yes
Trauma/Abuse History	(•)	( )
Physical Abuse	(•)	( )
Sexual Abuse	(•)	( )

Comments:

Social History

Individual resides with: Mother

Has legal custody: Mother

Biological parents are: Divorced

How many people live in the home *not* including the individual being evaluated? 1

Who lives in the home?

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

Age: Years

Gender:

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

Comments:

Family History

Condition/Disorder

	Mom	Dad	Brother	Sister	Mat GM	Mat GF	Pat GM	Pat GF
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Attention-deficit/hyperactivity disorder (ADHD)	☐	☑	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☑	☐	☐	☐	☐	☐	☐
Seizure Disorder (e.g., epilepsy)	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Concerns (e.g., Depression, Anxiety Disorder, Bipolar)	☑	☑	☐	☐	☐	☐	☐	☐
Childhood deaths	☐	☐	☐	☐	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐	☐	☐	☐	☐

Dysmorphology	☐	☐	☐	☐	☐	☐	☐	☐
Substance use disorder	☐	☑	☐	☐	☐	☐	☐	☐

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)
- ☐ Day care center
- ☐ Preschool
- ☐ Head Start or Early Head Start
- ☑ School (K-12)

Grade level:

Twelfth Grade

Does the child participate in any of the following?

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

Comments:

Current Resources:

- ☐ Speech Language Therapy (SLT)
- ☐ Occupational Therapy (OT)
- ☐ Physical Therapy (PT)
- ☐ First Steps
- ☐ Parents as Teachers (PAT)
- ☐ Behavioral Therapy/ABA
- ☐ WIC
- ☐ Children's Division
- ☑ Counseling (play, trauma informed, PCIT)

- [ ] Psychiatric Services
- [ ] Regional Office for Developmental Disabilities (Dept. of Mental Health)
- [ ] Bureau of Special Health Care Needs
- [ ] Easter Seals
- [ ] Social Security Disability (SSI)
- [ ] Other
- [ ] None of the above

Please check all that apply

Comments

Screeners

Name of Screening Tool:

- [ ] CARS-2
- [ ] M-CHAT
- [ ] SCQ Current
- [ ] SCQ Lifetime
- [x] SRS-2
- [ ] Other

Social Responsive Scale Questionnaire, Second Edition (SRS-2)

Date of Administration (most recent): 03-23-2023 M-D-Y

Total Score: 53

Please describe any notable comments or concerns:

Normal range for all except for social cognition (i.e., 61) in the mild range.

Comments:

Adaptive Functioning Test

Name of Test:

Date of Administration (most recent): M-D-Y

Comments:

Intelligence/Developmental Testing

Name of Test: Other

Name of Other Test: WAIS-IV

Date of Administration (most recent): 03-28-2023 M-D-Y

Full Scale: 114
or Mullen ELC

Verbal Score:

Nonverbal Score:
or Mullen VS

Comments:

Verbal Comprehension: 130
Perceptual Reasoning 107
Working Memory 95
Processing Speed 111
GAI 121

Other Tests/Assessments

Were any other tests or assessments completed?

- ○ Yes
- ◉ No

Autism Diagnostic Observation Schedule Revised

Date of Administration: M-D-Y

Module:

Was the administration valid? ○ Yes ○ No

Please note any validity concerns:
(Note any circumstances with performance, such as fatigue, interruptions, changes to standard administration, etc. Ex: E-codes)

Social Affect (SA) Score:

Restricted Repetitive Behaviors (RRB) Total:

Overall Total:

Comparison Score:

DSM-5

Instructions: Based on all available information provided during the parental interview and direct observation via the ADOS-2 and other development assessments, please use DSM-5 criteria to complete the following checklist. Please note any discrepancies between parent interview and direct observations.

Date of Completion: M-D-Y

Section A: Social Communication

A1. Deficits in social-emotional reciprocity;
ranging from abnormal social approach and failure of normal back and forth conversation, to reduced sharing of interests, emotions or affect; to failure to initiate or respond to social interactions.

○ **0 (Absent)** ○ **1 (Subthreshold)** ◉ **2 (Present)**

Justify or explain your observations of this behavior:

A2. Deficits in nonverbal communicative behaviors used for social interaction;
ranging from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body-language or deficits in understanding and use of gestures; to total lack of facial expressions and nonverbal communication.

○ **0 (Absent)** ◉ **1 (Subthreshold)** ○ **2 (Present)**

Justify or explain your observations of this behavior:

A3. Deficits in developing, maintaining, and understanding relationships;
ranging from difficulties adjusting behavior to suit various social contexts; difficulties in sharing imaginative play or making friends; to absence of interest in peers.

○ **0 (Absent)** ○ **1 (Sub-Threshold)** ◉ **2 (Present)**

Justify or explain your observations of this behavior:

Section B: Restricted/Repetitive Behavior

B1. Stereotyped or repetitive motor movements, use of objects, or speech;
such as simple motor stereotypes, lining up toys or flipping plates, echolalia, idiosyncratic phrases.

◉ **0 (Absent)** ○ **1 (Sub-Threshold)** ○ **2 (Present)**

Justify or explain your observations of this behavior:

B2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior;
such as extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat the same foods every day.

○ **0 (Not Present)** ◉ **1 (Sub-Threshold)** ○ **2 (Present)**

Justify or explain your observations of this behavior:

B3. 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.

◉ 0 (Absent) ○ 1 (Sub-Threshold) ○ 2 (Present)

Justify or explain your observations of this behavior:

B4. Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment;
such as apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights of movement.

◉ 0 (Absent) ○ 1 (Sub-Threshold) ○ 2 (Present)

Justify or explain your observations of this behavior:

Section C: History of Delays

C1: Symptoms must be present in early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learning strategies later in life)

○ Absent ◉ Present

Justify or explain your observations of this behavior:

Section D: Impairment

D1: Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning

○ Absent ◉ Present

Justify or explain your observations of this behavior:

Section E: Clinical Diagnosis

E1: Autism Spectrum Disorder

* must provide value

(●) Absent ( ) Present

In order for ASD to be checked as Present all items in Section A must be checked Present (or by history), at least 2 items from Section B checked Present (or by history), C1 checked Present, and D1 checked Present.

How confident are you in your diagnostic determination?

(●) Not confident
( ) Slightly confident
( ) Moderately confident
( ) Very confident

Strengths and Challenges

Please list three strengths for the individual:

1)

Committed to treatment and wants to be the "best" her she can be.

2)

Very open and honest about her own experiences, emotions, and feelings.

3)

Lots of positive support from her mother.

Please list three primary challenges for the individual:

1)

Inconsistent reporting from both and her mother, especially complicated that her mother is a psychologist and has strong feelings against a diagnosis.

2)

Social challenges are persistently present and significantly impact her. She is very emotionally and behaviorally reactive to negative interactions between herself and her peers and a lot of distress related to not having a partner.

3)

Eating symptoms complicate the picture, though I believe are likely best attributed to rigidity.

Recommendations:

Based on my evaluation, the following recommendations are proposed for the individual:

1)

Discuss medication management with pediatiricna and possible a psychiatrist.

2)

Engage in therapy.

3)

Monitor eating disorder symptoms consistently for immediate transfer to an eating disorder specialist.

4)

School recommendations related to mathematics accommodations.

5)

Engage in extracurricular activités to increase opportunities for engagement with same-age peers.

6)

Consider an ASD evaluation.

Form Status

Complete? Complete