

## ADX CASE Form

Response was completed on 02/14/2024 11:51am.

Record ID

6

# ECHO **Autism**: Advanced Diagnosis Case Presentation Form

**Valeria Nanclares, Psy. D.; Kristin Sohl, MD;  
Melinda Odum, LCSW; Alicia Curran, BS**

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](mailto: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:

Dalton Young

Clinic/Facility Name:

Compass Health Network

City:

Raymore

ECHO ID:

DX111

Presentation Date:

02-28-2024

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:**

7

1

**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:**

**What is the main language spoken in the home?**

**Which other languages are spoken in the home?**

- English  
 Arabic  
 Burmese  
 Chinese (e.g., Mandarin, Cantonese)  
 French  
 Navajo  
 Spanish  
 Tagalog  
 Vietnamese  
 Other

**What is the child's dominant language when communicating with others?**

# Patient Outcomes

Is this patient an existing patient or a new patient?

- Existing patient  
 New patient

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

Other

If other, please specify:

Compass Health CPRC Caseworker

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?

2 months

How long did it take you to complete your assessment?

2-3 weeks

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

1.5 months

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

Miles

30

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

Hours:

0

Minutes

30

## List the questions you would like help with.

1)

Recommendations on how to differentiate whether a child's behaviors are stemming from autism symptoms (i.e., sensory overstimulation or social difficulties with peers) or the child's behaviors are causing the social difficulties with peers.

2)

What is the theoretical cutoff for an interest to be considered "highly restricted, fixated interests that are abnormal in intensity or focus."

3)

Recommendations for child's treatment team, including outpatient therapist, psychiatrist, and individual and family caseworkers.

## Birth History

### Exposures during pregnancy:

Smoking  Alcohol  Valproic Acid  Street drugs  Other  Unknown

### Gestational age:

### Birth weight:

### Delivery mode:

Vaginal  C-section

### Presentation:

Breech  Head first

### Head circumference:

### 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:**

Around one year old

**Uses 2-3 word phrases:**

unknown

**Speak in full sentences:**

Around 2.5 years old

**Walking:**

18 months

**Daytime bladder control:**

3.5 years old

**Nighttime bladder control:**

Continues to "wet the bed every night"

**Bowel control:**

3.5 years old

**Social smile:**

Unknown

**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
- Chats with others
- Uses gestures (e.g., pointing, waving and/or leads other to wants/needs)

**Behavior Concerns**

- Short attention span
- Hyperactivity
- Unusual or excessive fears
- Self-injury (e.g., head banging, biting, scratching, cutting, picking, etc.)
- Irritability/Moodiness
- Depression
- Elopement/Running off
- Toileting issues, accidents
- 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:**

Mom commented: "I think it is more than DMDD."

## Medical/Psychiatric History

### Please list all diagnoses or illnesses:

**Diagnosis/Illness:**

**Age:**

**Date - Year:**

**Professional making diagnosis:**

**Diagnosis/Illness:**

**Age:**

**Date - Year:**

**Professional making diagnosis:**

**Diagnosis/Illness:**

**Age:**

**Date - Year:**

**Professional making diagnosis:**

**Diagnosis/Illness:**

### Please list current medications and supplements:

**Medication:**

**Dosage:**

Age when started:

6

Reason for medication:

ADHD

Is it helping?

Yes  No

Medication:

Abilify

Dosage:

5MG

Age when started:

6

Reason for medication:

DMDD

Is it helping?

Yes  No

Medication:

Lamictal

Dosage:

unsure

Age when started:

6

Reason for medication:

Seizures

Is it helping?

Yes  No

Medication:

Desmopressin

Dosage:

unsure

Age when started:

7

Reason for medication:

Nocturnal enuresis

Is it helping?

Yes  No

Medication:

## Additional Conditions

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:**

Two seizures: December 2022 and January 2023.  
Denied any absence seizures.

## Medical Testing

### Have the following medical tests been performed?

**Vision screening**

- Yes  No  Unknown

**Results:**

Wears glasses

**Audiologic (hearing) screening**

- Yes  No  Unknown

**Results:**

No hearing concerns

**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

### Results:

"came back negative" following seizures

## 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

### Is falling asleep a problem?

Yes  No

### 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	<input checked="" type="radio"/>	<input type="radio"/>
Physical Abuse	<input checked="" type="radio"/>	<input type="radio"/>
Sexual Abuse	<input checked="" type="radio"/>	<input type="radio"/>

Comments:

## Social History

Individual resides with:

Has legal custody:

Biological parents are:

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

### Who lives in the home?

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

Age:



<b>Learning Disability</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Seizure Disorder (e.g., epilepsy)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mental Health Concerns (e.g., Depression, Anxiety Disorder, Bipolar)</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Childhood deaths</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Birth defects</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dysmorphology</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Substance use disorder</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)
- Day care center
- Preschool
- Head Start or Early Head Start
- School (K-12)

**Grade level:**

First 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:**

Placed on an IEP in Kindergarten due to behaviors and suspensions.

Has multiple instances of ISS, OSS, and having to be picked up from school early due to meltdowns including throwing things, ripping things off the wall, and hitting and kicking peers.

Spends most of the day in the "special education classroom" and "has a one on one."

Client is currently "a little below grade level in reading and writing" and "doing okay in math."

## **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**

Client has been engaged in psychiatry services for one year.

Client has been engaged in PCIT for 6 months. Client and parent are excelling at PCIT in session and struggling to implement the skills at home.

## **Screeners**

### **Name of Screening Tool:**

- CARS-2
- M-CHAT
- SCQ Current
- SCQ Lifetime
- SRS-2
- Other

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

**Date of Administration (most recent):**

01-23-2024

**Total Score:**

73

**Please describe any notable comments or concerns:**

Social Awareness: 71  
Social Cognition: 67  
Social Communication: 70  
Social Motivation: 82  
RRBs: 66

**Comments:**

## Adaptive Functioning Test

**Name of Test:**

ABAS-3 

**Date of Administration (most recent):**

01-23-2024

**Composite Score:**

66

**Conceptual Score:**

73

**Social Score:**

71

**Practical Score:**

64

**Comments:**

Equivalent scores across subdomains ranging from 3 being the lowest on Self-Care to the highest being 6 on Communication and Self-Direction.

## Intelligence/Developmental Testing

**Name of Test:**

WISC-V 

**Date of Administration (most recent):**

01-23-2024

**Full Scale:**

70

or Mullen ELC

**Verbal Score:**

81

**Nonverbal Score:**

70

or Mullen VS

**Comments:**

May be an underrepresentation of actual abilities as client presented as fatigued during testing.

VCI: 81

VSI: 69

FRI: 69 - significant difference in subtest scores

WMI: 79 - significant difference in subtest scores

PSI: 75 - significant difference in subtest scores

## Other Tests/Assessments

**Were any other tests or assessments completed?**

Yes

No

**Name of Test:**

BASC-3

**Date of administration:**

01-23-2024

**Score:**

**Comments:**

At Risk scores:

Hyperactivity, anxiety, somatization, social skills, and functional communication

Significant scores:

Aggression, Conduct Problems, Depression, Withdrawal, Adaptability, Leadership

**Name of Test:**

**Date of administration:**

**Score:**

**Comments:**

**Autism Diagnostic Observation Schedule Revised**

Date of Administration:

01-23-2024

Module:

3

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)

Total score could not be calculated due to client unable to finish all required components (unable to complete relationship questions and create a story) on the ADOS-2. Client repeatedly tried to curl up in the chair and fall asleep and would not respond when spoken to.

Qualitatively within the administration:

significant difficulties engaging in back and forth conversations

Offered information about self and did not express interest in examiner (i.e., did not follow up on any prompts)

Maintained eye contact, integrated with verbal communication

Multiple instrumental gestures, no other gestures

Identified emotions of scared and angry in others

Difficulties understanding emotions and what causes her to feel certain emotions

One social smile towards examiner

Did not display any repetitive speech, behaviors, or restricted interests

Social Affect (SA) Score:

Restricted Repetitive Behaviors (RRB) Total:

Overall Total:

Comparison Score:

Classification:

## 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:

02-10-2024

## 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:**

Does not initiate or respond to social interactions with peers at school or within the context of the testing appointment. Conversations are often one sided with client talking about what she wants to talk about and does not express interest or awareness of others interest or role in the conversation.

**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:**

Client is able to integrate appropriate eye-contact and verbalization. Did demonstrate one social smile, while affect was fairly restricted during all other times. Client uses frequent instrumental gestures and no emphatic gestures.

**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:**

Significant difficulties making and maintaining friendships.  
Client currently has no friends and expresses little interest in making friends or having friends in the future.  
Client's mother reported that client is aggressive towards peers and "has to play her way" when she does interact with peers.

## 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:**

No reported or observed repetitive behaviors or speech.

**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:**

No observed insistence on sameness, ritualized patterns, or difficulties with flexibility during testing.

Client's mother reported the client is "thrown off" and "lashes out more" whenever there are small changes in her schedule at home.

**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:**

Possible restricted interest in cats. Client carries a stuffed cat with her, wears cat t-shirts, and talks more about her pet cat than any other topic of conversation. Client would bring up her pet cat in conversation during testing; however, the comments were often brief, and she could be redirected back on task.

Client's mother reported that client has been highly interested in cats for "three or four years."

**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 or movement.

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

**Justify or explain your observations of this behavior:**

Denied any sensory concerns except for being easily overstimulated by loud settings. Client is reported to get angry, lash out, cry, and cover her ears when around loud noises.

Client's mother reported that client had to change what bus she takes to school due to her previous bus being too loud and causing increased outbursts.

## 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:

Client's mother reported that social difficulties have been present since around the age of 4 when the client started HeadStart. Client's mother reported that client expressed little interest in making friends, had to play her way when she did engage with peers, and was aggressive (hitting and kicking) towards peers.

Client's mother reported possible restricted interest in cats since the age of 4.

Client's mother reported sensory sensitivities to loud noises throughout client's life.

## 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:

Client has significant difficulties making and maintaining relationships with peers which results in conflict at school. Client has received multiple ISS and OSS due to behavioral outbursts and aggressive behaviors towards peers.

Client has significant difficulties carrying on reciprocal conversations with peers and adults, as well as difficulties communicating her thoughts and feelings in a way that others are able to understand and offer support.

## 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)

Client appears to have a close relationship with her mother and is able to notice and support her mother when her mother is upset. Client has been working hard in PCIT to improve relationship and communication with mother.

2)

Client has been able to develop a good relationship with her school principal and will go to him for support in calming down when dysregulated at school. Client is reported to apologize to others when she behaves aggressively.

3)

Client has been working hard and improving at using a feelings chart to communicate how she is feeling and what she needs in the moment.

**Please list three primary challenges for the individual:**

1)

Client has significant difficulties regulating her emotions, which results in behavioral outbursts and acting aggressively.

2)

Client has significant difficulties getting along with peers at school and making and maintaining relationships.

3)

Client has difficulties in adaptive functioning, most prominently in practical skills, such as self-care and daily living skills.

## **Recommendations:**

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

1)

Client is encouraged to continue psychiatry services to support ADHD and DMDD symptoms.

2)

Client is encouraged to continue PCIT services to improve communication and relationship with her mother and continue working towards implementing those skills at home.

Following completion of PCIT, client may benefit from behavioral therapy to further develop skills to regulate emotions and reduce aggressive behaviors.

3)

Client may benefit from participating in structured social activities or organizations (i.e., organized sports, Girl Scouts, etc) to practice social skills in a structured and organized setting with set rules and expectations.

4)

Client is encouraged to continue working with the neurologist to monitor seizures and evaluate the impact of seizures on client's symptoms.

5)

Client's mother and teachers are encouraged to assist client in identifying her emotions and helping her use a corresponding coping skill to regulate. This may include modeling using coping skills when the parent or teacher themselves may be feeling dysregulated. It is important for client's mother and teachers to be mindful that client's uncooperative behaviors may be due to feeling confused, anxious, or overwhelmed and to validate the underlying emotions.

6)

Client is encouraged to maintain her IEP at school for continued support across emotional, behavioral, and academic functioning.

---

**Form Status**

**Complete?**

Complete ▼