EI Case Presentation

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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:	Susan Sappington
ECHO ID:	EI0057
Clinic/Facility:	First Steps
	Columbia
Provider Phone Number:	573-999-6285
Provider Fax Number:	888-388-1944
Presentation date:	04-22-2024 M-D-Y

Patient Data

Biological Gender:

(•) Male ( ) Female ( ) Unsure

Patient Age: 3

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Insurance: Private

Insurance Company: unsure

Race: Black/African American

Ethnicity: Not Hispanic/Latino

Patient Outcomes

Who referred the child to you? Community physician/practitioner

How long has the child been in your care? April 2022-August 2023

Has the patient received a diagnosis? Yes

If so, when? prior to age 2

By which physician? Thompson Center

How long did the patient have to wait to see you? less than 1 month

How long has the patient been in your care? April 2022-August 2023

Is the patient in individual or group intervention? Individual

How often do you see the patient? 1x/week then increased 2x/week

How many sessions have you had with the patient?

Who typically accompanies the patient to clinic appointments? Seen in home primarily with some community

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

Miles: 0

Hours: 0

Minutes: 0

List the questions you would like help with.

1)

What other therapies or supports could have been added to his team to maximize outcomes and develop primary skills before moving on to ECSE?

2)

Mom would like some suggestions to decrease the high pitched squealing and screaming that happens several times an hour. Mom would also like some supports/suggestions for feeding. Currently on waitlist for OT.

3)

What additional training should or could SLPs obtain to increase competence in working with children with significant sensory needs? Should OT have been primary? (OT initially 2x month then increased to 1x week).

Birth History

Exposures during pregnancy:

☐ Smoking ☐ Alcohol ☐ Valproic Acid ☐ Street drugs/other ☑ Unknown

Other:

Gestational age: 34 (weeks)

Birth weight: 4 (lbs) 6 (oz)

Delivery mode:

○ Vaginal ◉ C-section

If C-section, why? Previous C-section and heart rate decline during labor

Presentation:

○ Breech ○ Head first

Were there newborn problems?

◉ Yes ○ No

If yes, explain:

Please check all of the following that apply:

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

Comments:

To gain weight

Development History

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

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

Behavior Concerns

- [x] Short attention span
- [x] 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
- [x] Irritability/Moodiness
- [ ] Hallucinations

Comments:

Child is trialing an AAC device to use at home and at school. Using a few icons at school and a couple at home with prompting.

Medical/Psychiatric History

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

Diagnosis/Illness:

Significant environmental allergies and asthma. Makes gagging sound frequently but physical structure issues ruled out. Was suspected to be GERD and put on famoditine.

Age: 2

Date - Year: 5/2022

Professional making diagnosis: Primary

Diagnosis/Illness:

Autism Spectrum disorder

Age: prior to age 2

Date - Year: Early 2022 before referral to FS

Professional making diagnosis: Thompson Center

Diagnosis/Illness:

Please list current medications and supplements:

Medication: Zyrtec , benedryl, flonase, albuteral

Dosage: dosage based on child age/weight

Age when started: prior to age two as well as ongoing

Reason for medication: Allergies and asthma

Is it helping? ◉ Yes ○ No

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:

Possible PE tubes in near future due to multiple ear infections

Testing

Have the following tests been performed?

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

Lead blood level

○ Yes ◉ No ○ Unknown

Audiologic (hearing) exam

(•) Yes ( ) No ( ) Unknown

Results: WNL

Vision screening

(•) Yes ( ) No ( ) Unknown

Results: WNL

Academic testing

( ) Yes (•) No ( ) Unknown

Intelligence testing

( ) Yes (•) No ( ) Unknown

Comments:

Dietary/Nutrition/Metabolic

Please check all of the following that apply:

- [x] 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
- [x] Juice/Sweetened beverages

Approximately how much juice does the child drink per day? over 20 ounces (oz)

Does child drink more than 24 oz juice per day?

(•) Yes ( ) No ( ) Unknown

How often is juice accessible?

( ) At meals/snack time (•) Access to juice available all day

Comments:

Waters down juice

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

Comments:

Mom has to hold to sleep; occasionally using weighted blanket, sometimes just wants light blanket

Trauma/Abuse History

	No	Yes	Suspected
Trauma/Abuse History	◉	○	○
Physical Abuse	◉	○	○
Sexual Abuse	◉	○	○

Comments:

Social History

Child resides with: Mother

Has legal custody of the child: Both parents

Biological parents are: Never married

How many people live in the home *not* including the child? 3

Who lives in the home with the child?

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

Age: 11 (yrs) (mos)

Gender: Female

Relationship: brother

Age: 26 years (yrs) (mos)

Gender: Male

Relationship: mom

Age: 40's (yrs) (mos)

Gender: Female

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

Grandma(mom's mom) and his dad.

Comments:

Mom reported limited support from her mom who is caring for her aging parents, and dad helps occasionally and only takes child overnight if there is an emergency.

Family History

Condition/Disorder

	Mom	Dad	Brother	Sister
Genetic Disorders	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☑
Seizure Disorder (e.g., epilepsy)	☐	☐	☐	☐
Mental Health Concerns (e.g., Depression, Anxiety Disorder, Bipolar)	☑	☐	☐	☐

Childhood deaths	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐
Dysmorphology	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐

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

What services and how many minutes does the child receive?

ECSE Monday through Thursday 9-12; ABA in local clinic two afternoons a week until 3 pm (dad transports to); full day ABA at local clinic on Fridays.

Under what category is the child eligible for services?

- ☐ Autism
- ☐ Deaf-blindness
- ☐ Emotional Disturbance
- ☐ Hearing Impaired/Deafness
- ☐ Intellectual Disability

- [ ] Multiple Disabilities
- [ ] Orthopedic Impairment
- [ ] Other Health Impairment
- [ ] Specific Learning Disability
- [ ] Speech/Language Impairment
- [ ] Traumatic Brain Injury
- [ ] Visual Impairment/ Blindness
- [x] Young Child with a Developmental Delay (YCDD)

Comments:

Outside Resources

Resources:

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

Other resource/s: Boone County Family Resources

Is Counseling provided in an outpatient or school setting?

- (•) Outpatient
- ( ) School Setting
- ( ) Both

Is Speech Language 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

Mom gets the counseling

On waitlist for OP OT

Social Communication

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

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

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

- [x] Impairments in social use of eye contact
- [x] Impairment in the use and understanding of body postures (e.g. facing away from listener)
- [x] Impairment in the use and understanding of gestures (e.g. pointing, waving, nodding head)
- [x] Abnormal volume, pitch, intonation, rate, rhythm, stress, prosody or volume in speech
- [x] 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)
- [x] Does not notice another person's lack of interest in an activity
- [x] Lack of response to contextual cues (e.g. social cues from others indicating a change in behavior is implicitly requested)
- [x] Inappropriate expressions of emotion (laughing or smiling out of context)
- [x] Lack of imaginative play with peers
- [x] Does not try to establish friendships
- [x] Lack of cooperative play (over 24 months of age)
- [x] Lack of interest in peers
- [x] Withdrawn; aloof; in own world
- [x] Prefers solitary activities

Restricted/Repetitive Behavior

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

- [ ] Lining up toys
- [x] 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)
- [x] 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
- [x] 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

- [x] Difficulty with transition
- [ ] Unusual routines
- [ ] Repetitive questioning about a particular topic
- [x] 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)
- [x] 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
- [x] 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

- [x] 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
- [x] Visual fascination with lights or movement (Examples: close visual inspection of objects or self for no clear purpose)
- [x] Excessive movement, seeking behavior

Additional Comments

Proposed Recommendations:

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

1)

2)

3)

4)

5)

6)

Form Status

Complete? Complete