TOUCHPOINT PEDIATRICS, P.A.

November 14, 2012

In 2007, the State established the NJ Autism Registry in order to improve services for New Jersey children affected by Autism. This registry enables the State to plan and provide services to autistic children and their families. Health care providers are required to register any person under the age of 22 and a resident of NJ. At this time, your child is not registered and we would like your help in accomplishing this task. Registration will allow you to receive information about services available and you will be linked to the Case Management Unit in your county.

Please go to our website, touchpointpediatrics.com, click on the Autism Registry button and download the instructions, forms and brochure. Please complete the forms to the best of your ability and send them back to us within two weeks. We will then add any other information we have and forward it to the Autism Registry.

You ***cannot refuse*** to have your child registered but you can ask that personal identifying information such as name and address be withheld. If this is your choice, you need to send us back this signed letter (*see below*) indicating that request along with the completed registration. We will abide by your wishes and will only forward non-identifying data to the State. In that case, the State will not reach out to you with information about services nor link you to the Case Management Unit in your county.

If you have any questions, you can call the Registry at 609-292-5676. You can also call and speak with our nurse Pat.

Thank you for your cooperation in this matter. It is important to us that our patients receive all the assistance that is appropriate and available to them to manage the many issues associated with this diagnosis. Our goal is always to have our patients reach their maximum potential.

Sincerely,

Jennifer Shaw-Brachfeld, MD

Valerie Tom, MD

Margot Kerrigan, MD

Stuart Slavin, MD

Please withhold my child's name and address when including him/her in the Autism Registry.

Child's name: _____ _____ _____

Print Name *Date of Birth* *Today's Date*

Parent/Guardian: _____ _____

Print Name *Signature*

17 Watchung Avenue • Chatham, NJ 07928 • Phone 973.665.0900 • Fax 973.665.0901

SPECIAL CHILD HEALTH SERVICES
REGISTRATION, Form SCH-0
INSTRUCTIONS AND LEGENDS

INSTRUCTIONS

Registration Type
- New – first time a child is registered by hospital/reporting facility, also use when Registration type is unknown.
- Update – updated information for a child previously known to be registered by hospital/reporting facility.
- Audit – child found to be the result of an audit conducted by state Birth Defects Registry staff.

Type of Hospital/Reporting Facility
- Refer to legend below, choose the most appropriate.

Case Tracking Information
- Provide if available – used to identify updated registrations from same hospital/reporting facility or duplicate registrations from separate hospitals.

Name of Contact
- Individual from hospital/reporting facility who is to be contacted regarding any questions concerning the registration – there should only be one person per hospital/reporting facility designated as the contact person.

Child's Information
- Use information as it appears on the Birth Certificate.

Child's Current Residence
- Should reflect the address where the child resides at the time of registration.
- If a child is living in a facility, then the facility's address is entered in this section.
- Unit description – refer to legend below.

Hospital/Place of Birth
- If the birth took place in a New Jersey facility, then the name of the facility should be written in the space.
- If the birth took place in New Jersey, but not at a medical facility, then write "NJ – non-medical facility" in the space.
- If the birth took place in NY, PA, DE, or MD, then refer to legend below for a list of selected hospitals that should be written in the space.
- If the birth took place in the United States, but not in New Jersey or at one of the selected hospitals listed in the legend below, then write "out-of-state" in the space and the city and state in which the birth occurred.
- If the birth was a "home" birth, then write "Home Birth" in the space and the city and state in which the birth took place.
- If the birth took place outside of the United States, then write "out-of-country" in the space and the name of the country.
- If the birth place is unknown, then write "unknown" in the space.

Transfer Information
- Provide information on only the most recent transfer.
- Only the hospital/facility name should be written into the space for "received from" and "sent to".
- In the case of a "home" birth, the child is considered a transfer and the "received from" space should reflect the manner in which the child was transported to the hospital, e.g., ambulance, private car, taxi, etc.

Birth Information
- Birth order should be a number only, e.g., 1, 2, rather than an alpha character (A,B).

Primary Language Spoken in Home
- Refer to legend below.

Birth Mother's Residence at Time of Birth
- As the address appears in the Electronic Birth Certificate.
- If the birth mother was institutionalized at the time of birth, then the address immediately prior to institutionalization should be used, unless she became pregnant while institutionalized, in which case use the address of the institution.
- If the birth mother is homeless, then use the last known address.
- If the birth mother's residence at time of birth is unknown, then check unknown.

Parent A Information
- If one parent is the birth mother, then Parent A Information should correspond to the birth mother.
- If neither parent is the birth mother, but one parent is a biological parent, then Parent A Information should correspond to the biological parent.
- If neither parent is a biological parent, then Parent A Information may correspond to either parent.
- Biological – if the biological connection of the parent is known, then either the "yes" or "no" box should be checked; if the biological connection of the parent is unknown, then the "unknown" box should be checked.
- Maiden Name – if applicable, complete, otherwise write "NA".
- Mailing Address – the address used to send mail to the parent (should be the same as in the Electronic Birth Certificate); if the mailing address is the same as the child's current address, then check "same as child's current residence address" box.
- Legal Guardian Status – reflects the parent's legal authority to act on behalf of the child; a biological parent is assumed to be the child's legal guardian unless a court has terminated guardianship; a non-biological parent's guardianship is assigned by the courts; if the guardian status is unknown, then check the "unknown" box.

Parent B Information
- Corresponds to the other parent.
- If unknown, then leave blank.
- Biological – if the biological connection of the parent is known, then either the "yes" or "no" box should be checked; if the biological connection of the parent is unknown, then the "unknown" box should be checked.
- Mailing Address – the address used to send mail to the parent (should be the same as in the Electronic Birth Certificate); if the mailing address is the same as the child's current address, then check "same as child's current residence address" box.
- Legal Guardian Status – reflects the parent's legal authority to act on behalf of the child; a biological parent is assumed to be the child's legal guardian unless a court has terminated guardianship; a non-biological parent's guardianship is assigned by the courts; if the guardian status is unknown, then check the "unknown" box.

Guardian Agency Information
- Legal Guardian Status – reflects the legal authority to act on behalf of the child and is assigned by the courts; if the guardian status is unknown, then check the "unknown" box.
- Guardian Type – categorizes the guardian as either an agency (government or private) or an individual (relative or non-relative); if the child is placed with a Foster Parent, then the Guardian Type is "Individual (Non-Relative)"; a DYFS case must have signed documents denoting such.

- Guardian Agency Information - corresponds to the government or private agency assigned guardianship of the child.
- Guardian Agency Contact Information - corresponds to the individual at the government or private agency who should be contacted regarding any questions concerning the child.

Guardian's Information

- Corresponds to the individual (relative or non-relative) who is assigned guardianship of the child; only a single name should be entered, e.g., John Jones or Mary Jones, even though the guardians may be John Jones and Mary Jones.
- Mailing Address – the address used to send mail to the guardian; if the mailing address is the same as the child's current address, then check "same as child's current residence address" box.

Diagnosis Description

- Diagnosis should reflect physician's diagnosis, as noted on the medical record.
- Do not use diagnosis from medical records sheet.
- Do not use diagnosis based on only ICD-9 CM code.

LEGENDS

Type of Hospital/Reporting Facility

- Acute care hospital (ACH)
- Birthing center – free standing not hospital based (BC)
- Case Management Unit (CMU)
- Clinical laboratory (CL)
- County government agency (DOH, etc.) (CGA)
- Day care/school (DCS)
- Early Intervention (EI)
- Home health agency (HHA)
- Long-term care hospital (LTCH)
- Medical/Dental practice (MDP)
- Medical examiner (ME)
- Municipal/City government agency (MCGA)
- Other professional practice (Audiologists, etc.) (ProP)
- Other
- Parents/relative (PR)
- Specialty center (SpecC)
- State government agency (DYFS, etc.) (SGA)

Selected Out-of-State Hospitals

New York

- Bellevue Hospital
- The Children's Hospital of New York - Presbyterian
- Elmhurst Hospital Center
- Lenox Hill Hospital
- Lincoln Hospital
- Long Island College Hospital
- Long Island Jewish Hospital
- Montefiore Medical Center
- Mount Sinai Medical Center
- New York University Medical Center
- Sloan Kettering Hospital
- St. Anthony (Warwick)
- St. Clare's Hospital
- St. Luke's Medical Center
- Westchester Medical Center

Pennsylvania

- Abington Memorial Hospital
- Albert Einstein Medical Center
- Children's Hospital of Philadelphia (CHOP)
- Hahnemann Medical College
- Hospital of the University of Pennsylvania
- Pennsylvania Hospital
- St. Christopher's Hospital for Children
- Thomas Jefferson University
- Temple University Hospital
- Wills Eye Hospital

Delaware

- Al DuPont Hospital for Children
- Christiana Children's Hospital

Maryland

- Johns Hopkins Hospital

Unit Description (address)

- APT (Apartment)
- BSMT (Basement)
- DEPT (Department)
- FL (Floor)
- FRNT (Front)
- REAR (Rear)
- RM (Room)
- STE (Suite)
- UNIT (Unit)

Primary Language

- English
- Spanish
- American Sign Language
- Augmentative Communication
- Afghani
- African
- Arabic
- Cambodian
- Cantonese
- Chinese
- Farsi
- French
- French Creole
- German
- Hebrew
- Hindi
- Hmong
- Japanese
- Korean
- Laotian
- Mandarin
- Native American
- Pacific Islander
- Persian
- Polish
- Portuguese
- Russian
- Scandinavian
- Tagalog
- Turkish
- Vietnamese
- Yiddish
- Other
- Unknown

Autism Supplemental Information (SCH-1) Form
- Required component for Autism reporting
- Information is specific to the diagnosis of autism

Non-identifiable Registration
- If parent/guardian requests a non-identifiable registration, then check this box.
- Applies to Autism only registrations – congenital diagnoses registrations require all information on SCH-0 Form.
- Write pre-printed number from the SCH-0 Form (if using the pre-printed SCH-0) in place of the child's name.
- Report only month and year of birth.

Registration Type
- First registration – first time a child is registered by diagnostician or diagnostician's practice when the diagnostician is a member of a group practice.
- Revised – updated diagnosis information for a child previously registered by diagnostician.

Diagnosis
- Only one diagnosis may be selected.
- Autism Spectrum Disorders is a category heading and shall not be selected as a diagnosis.
- If Rett Syndrome selected, then indicate whether or not the diagnosis was confirmed by genetic tests.
- No longer meets criteria or Misdiagnosis – previously registered but no longer meets criteria.

Date of Diagnosis
- Complete mmddyy date is preferred; however, at least month and year must be reported. This reflects the date of service which prompted this registration.

Instruments/References used
- Check all instruments/references used to determine the diagnosis reported on this registration.
- If the diagnosis type is "No longer meets criteria" or "Misdiagnosis", then check all instruments/references used to determine that diagnostic criteria were not met.

Date First Diagnosed with Autism
- Date of initial, first ever, Autism diagnosis - complete mmddyy date is preferred; however, at least month and year must be reported.
- Same as Today, if this registration is the first ever diagnosis known to Diagnostician or Diagnostician's Practice.
- Unknown, if child previously diagnosed, but date is unknown.

Age Symptoms First Noted
- Age, in years or months or a combination, at which anyone, e.g., family member, medical provider, etc., noted symptoms (e.g. communication issues, social issues, restricted/ stereotyped/repetitive behaviors) associated with diagnosis reported on this registration.

Sibling Information
- Age, in years or months or a combination of each sibling at time of this registration.
- Indicate if the sibling is also diagnosed with an Autism Spectrum Disorder.
- Unknown if age of sibling is unknown

Diagnostician Information
- Corresponds to the individual who made the actual diagnosis.
- Credential and specialty information is required.
- If the diagnostician's practice is located within NJ, then a complete address should be provided.
- If the diagnostician's practice is located within the U.S., but not in NJ, then at least the city and state must be provided.
- If the diagnostician's practice is located outside of the United States, then at least the country must be provided.

Person Submitting Report
- Check appropriate box.
- If person other than diagnostician or diagnostician's staff is submitting this registration, then complete practice/facility name and all contact information.

Special Child Health Services (SCH-0) Registration Form
- Required component for autism reporting.
- Information to be completed depends upon whether the report is for autism only diagnosis or the report includes other congenital diagnoses normally reported to the State Birth Defects Registry.
- Follow Special Child Health Services (SCH-0) Form instructions unless otherwise noted below.

SCH-0 Form Sections to Complete: Autism Only Registration
- Registration Type
  - o New – registering child as a "First Registration".
  - o Update – when registering child as a "Revised or Updated Registration".
- Family Informed
- Type of Hospital/Reporting Facility
- Registering Agency Name
- Insurance Type
- Name of Child, Also Known As
- Child's Current Residence Address
- Hospital/Place of Birth
- Primary Care Provider
- Date of Birth
- Sex
- Plurality, Birth Order
- Ethnicity Information, whole section
- Birth Mother's Residence at Time of Birth
  - o If the birth took place in New Jersey, then report city, county and state.
  - o If the birth took place in the United States, then report city and state.
  - o If the birth took place outside the United States, then report country.
- Death Information
- Parent A Information
  - o Do not report Ethnicity Information
- Parent B Information
- Guardian Agency Information
- Guardian's Information
- Diagnosis Description for Other Comorbid Diagnoses

Autism with Other Congenital Diagnoses
- All sections to be completed as per SCH-0 Form instructions.

Non-Identifiable Autism Only Registration
- Applies to Autism Only registrations – congenital diagnoses registrations require all information on SCH-0 Form.
- Report all information as above, except:
  - o Do NOT report name information for child, parent A, parent B, or individual guardian.
  - o Report only county, state, and country address information for the child, parent A, parent B, or individual guardian.
  - o Report only month and year of birth.

Autism Registrations: Quick Reference Guide on Completing the Forms

Autism ONLY (no other registerable conditions)

1. Complete the SCH-0 Form (Birth Defects Registration Form) and the SCH-1 Form (Autism Supplemental Information)

AND

2. OMIT the following on the SCH-0 form:
    a. Medical Record #
    b. Hospital Contact
    c. Transfer Information
    d. Street or PO Box information for Birth Mother's Residence at Time of Birth
    e. Parent A Ethnicity Information

Anonymous Autism ONLY (no other registerable condition)

1. Complete the SCH-0 Form (Birth Defects Registration Form) and the SCH-1 Form (Autism Supplemental Information)

AND

2. OMIT the following on BOTH forms:
    a. All the Autism ONLY information above PLUS
    b. Name of Child & Parents/Caregiver
    c. Mother's residence at the time of birth (all information)
    d. Address for Parent A, Parent B, and/or Guardian except for county and state.
    e. The day of the child's date of birth (NOTE: you still need the month and year of the child's date of birth and the parents' date of birth)

Autism AND Mandatory Condition Registration (i.e., BDR)

1. Complete the SCH-0 Form (Birth Defects Registration Form) and the SCH-1 Form (Autism Supplemental Information)

AND

2. OMIT nothing

Anonymous Autism AND Mandatory Condition Registration (i.e., BDR)[1]

1. Complete the SCH-0 Form (Birth Defects Registration Form) and the SCH-1 Form (Autism Supplemental Information)

AND

2. OMIT the following on the SCH-1 Form (Autism Supplemental Information):
    a. Name of Child
    b. Day of the child's date of birth (Note: you still need the month and year of the child's date of birth)

[1] NOTE: These forms need to be completed separately for the child so that their information is not linked. Although a registration for autism can be anonymous (with no identifiable information), a BDR registration cannot be anonymous.

How private is my child's information?

We recognize the sensitivity of your information and respect the rights of all individuals with Autism and their families. We take seriously our obligation to protect the privacy and confidentiality of individuals and we keep all personal information in a tightly secured location.

Can you refuse to have your child registered?

No, but you can ask your health care professional not to include your child's personal information such as their name and address on the registration form.

However, if your child's personal information is not included:

- We will not be able to link your child to important services and resources, or your county-based case management unit.
- Your health care provider will need a signed written statement from you for their files,
- Your child's non-identifying information such as sex, month and year of birth, and county of residence will still be registered.

For Questions about the Registry, please call:

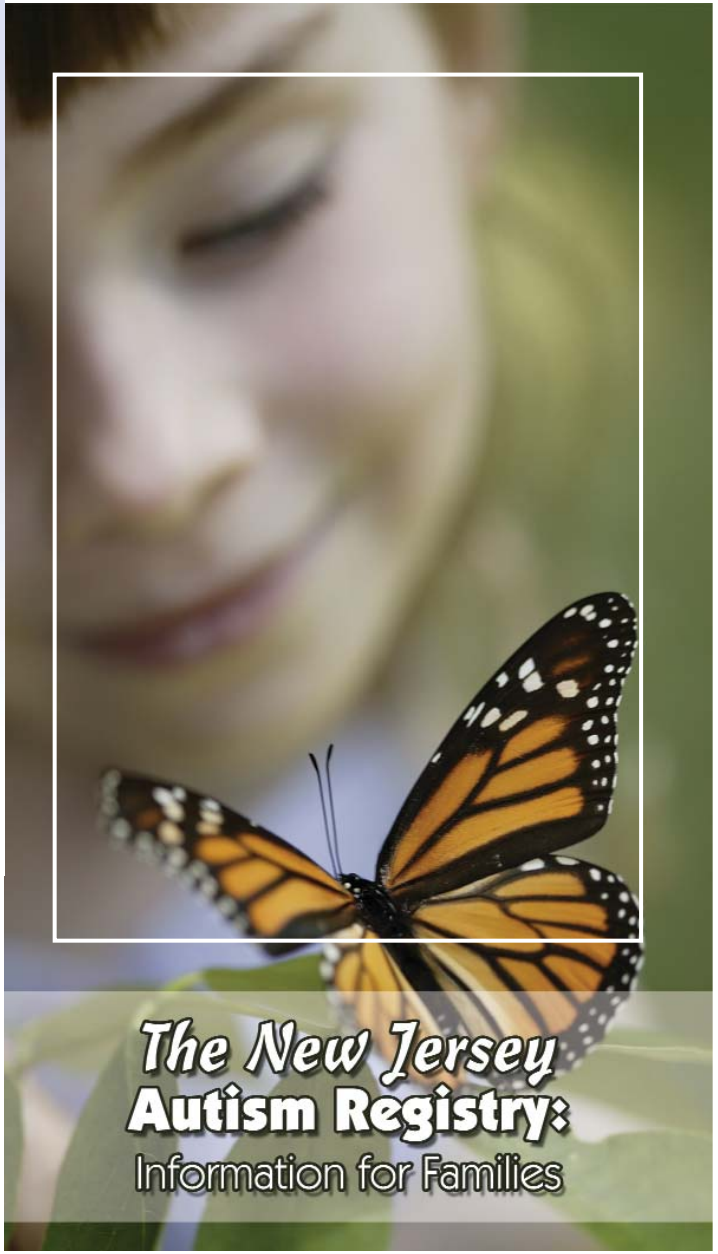
609-292-5676

If you need services, visit our website at:
http://www.state.nj.us/health/fhs/sch/index.shtml
or

- For children birth to age three with developmental delays and disabilities, please call 1-888-653-4463
- For children birth through age 21 with special health care needs, each county's telephone number can be found on our website: http://www.nj.gov/health/fhs/sch/sccase.shtml or by calling 609-777-7778

The Autism Registry is part of the New Jersey Department of Health & Senior Services
Division of Family Health Services
Special Child Health and Early Intervention Services
PO Box 364
Trenton, NJ 08625-0364

C1576



The New Jersey Autism Registry:

Information for Families

Chris Christie
Governor
Kim Guadagno
Lt.Governor

Dr. Poonam Alaigh
Commissioner

What is Autism?

Autism is a condition that affects a child's development and function in social interactions, communication, and patterns of behavior. In the New Jersey Autism Registry, we include diagnoses commonly known as the Autism Spectrum Disorders (ASD). These include Asperger Syndrome, Autistic Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS), Rett Syndrome and Childhood Disintegrative Disorder. If your child has been diagnosed with one of these conditions they are included in the registry.

How will my child be registered?

Your health care provider will register your child by completing specific forms and submitting them to the Department of Health and Senior Services. Only children who are New Jersey residents and under the age of twenty-two will be registered.

Your provider must inform you about the registry. If you are unsure if your child has been registered and would like to have your child registered, please contact your health care provider.

What information about my child will be reported to the registry?

The registry will be collecting information such as:

- Your child's name, address, date of birth, gender, and race,
- Your child's diagnosis, when you first noticed symptoms, and when they were diagnosed,
- Information about the provider who made the diagnosis.

Why is my child's name and personal information being collected?

Personal information is collected so that:

- You can be referred to the Special Child Health Services Case Management Unit in your county for help with resources.
- If your child's information or diagnosis changes, we are able to update the registry.

Will I be contacted?

Yes. Once your child is registered, you will receive a letter and informational pamphlets telling you that your child has been registered, and about services that may be available for you and your family. A person from your county's Special Child Health Services Case Management Unit will contact your family and inform you of available family-centered services in your community. County-based case management units assist families of children from birth to 21 years of age with special health care needs.

Why should my child be registered?

Over the last several years there has been an increase in the number of children diagnosed with Autism. While we don't know the reasons for this increase, we also don't know how many more children are being diagnosed and need services. To best serve children with Autism, we need to know how many children are being diagnosed so that we can plan and provide services to them and their families. It's important that your child be registered, so that your family can be notified of these services, many at no charge to the families.

New Jersey Department of Health and Senior Services
Special Child Health and Early Intervention Services
STATE BIRTH DEFECTS REGISTRY
PO Box 364, Trenton, NJ 08625-0364

SPECIAL CHILD HEALTH SERVICES
REGISTRATION

REGISTRATION INFORMATION

Registration Type: ☐New ☐Update ☐Audit

Family Informed of Registration: ☐ Yes ☐No

Type of Hospital/Reporting Facility

Registering Agency Name

CASE TRACKING INFORMATION

Medical Record Number

Electronic Birth Certificate (EIN) No.

INSURANCE INFORMATION

Insurance Type: ☐None ☐Private ☐Medicaid ☐Unknown

HOSPITAL/AGENCY CONTACT

Name of Hospital/Agency Contact *(Last, First, Middle, Suffix)*

Job Title

Telephone Number
( )

CHILD'S INFORMATION

NAME OF CHILD (AS APPEARS ON BIRTH CERTIFICATE)

Last Name | Suffix

First Name ☐ None Given | Middle Name

ALSO KNOWN AS

Last Name | Suffix

First Name ☐ None Given | Middle Name

CHILD'S CURRENT RESIDENCE ADDRESS

Street Address

Unit Description | Unit | P.O. Box

City | State

Zip Code | County | Country

HOSPITAL / PLACE OF BIRTH

Medical Facility Name or Description of Location

City | State | Country

PRIMARY CARE PROVIDER AFTER DISCHARGE

Practice Name -OR- Provider Name *(Last Name, First Name)* ☐ Undecided ☐ Unknown

Telephone Number | Extension
( )

TRANSFER INFORMATION

Child Transferred: ☐ Yes ☐ No | Date of Transfer

Received From

Sent To

CHILD'S INFORMATION, CONTINUED

BIRTH INFORMATION

Date of Birth | Sex: ☐ Female ☐ Male ☐ Indeterminate

Birthweight
_____ Grams –OR- _____ Lbs., _____ Ozs. -OR- ☐ Unknown

Plurality: ☐ Single ☐ Twin ☐ Other Multiple: _____ ☐ Unknown | Birth Order

Outcome: ☐ Live | Weeks of Pregnancy: ☐ Preterm (<37 Wks.) ☐ Term (37-41 Wks.) ☐ Post term (≥42 Wks.) ☐ Unknown

ETHNICITY INFORMATION

Hispanic/Latino: ☐ Yes ☐ No ☐ Unknown

Primary Language Spoken in Home: ☐ English ☐ Spanish ☐ Other, Specify: _____

Race *(Check ALL that apply)*

☐ White
☐ Chinese
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Asian Indian
☐ Black/African American
☐ American Indian/Native Alaskan
☐ Native Hawaiian
☐ Filipino
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Asian, Specify: _____
☐ Other Pacific Islander, Specify: _____
☐ Other, Specify: _____
☐ Not Classifiable / Unknown

BIRTH MOTHER'S RESIDENCE AT TIME OF BIRTH

IF MOTHER WAS INSTITUTIONALIZED AT TIME OF BIRTH, ENTER RESIDENCE ADDRESS BEFORE SHE WAS INSTITUTIONALIZED

☐ Unknown ☐ Same as child's current residence address

Street Address

Unit Description | Unit | P.O. Box

City | State

Zip Code | County | Country

DEATH INFORMATION FOR CHILD

Is Expired: ☐ Yes ☐ No | Date of Death ☐ Unknown

Place of Death ☐ Unknown

Autopsy: ☐ Yes ☐ No ☐ Pending ☐ Unknown | Death Certificate Number

PARENT A INFORMATION

Parent A Vital Status: ☐ Alive ☐ Dead ☐ Unknown

Sex: ☐ Male ☐ Female | Biological: ☐ Yes ☐ No ☐ Unknown

PARENT A NAME

Last Name | Suffix

First Name | Middle Name

Maiden Name

SPECIAL CHILD HEALTH SERVICES REGISTRATION (Continued)

PARENT A INFORMATION, CONTINUED

PARENT A MAILING ADDRESS

☐ Same as child's current residence address

Street Address

Unit Description | Unit | P.O. Box

City | State

Zip Code | County | Country

Parent A Legal Guardian Status ☐ Yes ☐ No ☐ Unknown | Date of Birth

Telephone Number ( ) ☐ No Phone

ETHNICITY INFORMATION

Hispanic/Latino ☐ Yes ☐ No ☐ Unknown

Race *(Check ALL that apply)*

- ☐ White
- ☐ Chinese
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Black/African American
- ☐ American Indian/Native Alaskan
- ☐ Native Hawaiian
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Asian, Specify: _____
- ☐ Other Pacific Islander, Specify: _____
- ☐ Other, Specify: _____
- ☐ Not Classifiable / Unknown

PARENT B INFORMATION

Parent B Vital Status ☐ Alive ☐ Dead ☐ Unknown

Sex ☐ Male ☐ Female | Biological ☐ Yes ☐ No ☐ Unknown

PARENT B NAME

Last Name | Suffix

First Name | Middle Name

PARENT B MAILING ADDRESS

☐ Same as child's current residence address

Street Address

Unit Description | Unit | P.O. Box

City | State

Zip Code | County | Country

PARENT B INFORMATION, CONTINUED

Parent B Legal Guardian Status ☐ Yes ☐ No ☐ Unknown | Date of Birth

Telephone Number ( ) ☐ No Phone

GUARDIAN AGENCY INFORMATION

Legal Guardian Status
- ☐ Yes
- ☐ No
- ☐ Unknown

Guardian Type
- ☐ Relative
- ☐ Individual (Non-Relative)
- ☐ Government Agency (DYFS, etc.)
- ☐ Private Agency

GUARDIAN AGENCY INFORMATION

Agency Name

Division/Program

Street Address

Unit Description | Unit | P.O. Box

City | State

Zip Code | County | Country

GUARDIAN AGENCY CONTACT INFORMATION

Contact Name *(Last Name, First Name)*

Telephone Number ( ) ☐ No Phone

GUARDIAN'S INFORMATION

GUARDIAN NAME

Last Name | Suffix

First Name | Middle Name

CONTACT INFORMATION

Telephone Number ( ) ☐ No Phone

MAILING ADDRESS

☐ Same as child's current residence address

Street Address

Unit Description | Unit | P.O. Box

City | State

Zip Code | County | Country

DIAGNOSIS DESCRIPTION (Be Specific)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

STATE USE ONLY

_____ CN: _____

New Jersey Department of Health and Senior Services

Special Child Health Services - Registration
AUTISM SUPPLEMENTAL INFORMATION

REGISTRATION FOR

Last Name	First Name
Date of Birth	Sex ☐ Female ☐ Male

☐ Parent/Guardian Requests Non-Identifiable Autism Registration

Registering this Child for:
☐ First Registration ☐ Revised or Updated Registration

DIAGNOSIS INFORMATION FOR THIS REGISTRATION FORM

Diagnosis *(choose one)*:

Autism Spectrum Disorders:

☐ Autistic Disorder
☐ Pervasive Developmental Disorder NOS
☐ Asperger Syndrome
☐ Subtype not yet determined
☐ No longer meets criteria
☐ Misdiagnosis
☐ Rett Syndrome: Gene Confirmed? ☐ Yes ☐ No
☐ Childhood Disintegrative Disorder
Other, specify: _____

USE THE SCH-0 FORM TO REPORT ALL OTHER MEDICAL CONDITIONS

Date of Diagnosis (Month/Day/Year)

Instruments/References Used *(check all that apply)*:

☐ ABC	Autism Behavior Checklist
☐ ADI-R	Autism Diagnostic Interview - Revised
☐ ADOS	Autism Diagnostic Observation Schedules
☐ CARS	Childhood Autism Rating Scale
☐ DSM-IV-R	Diagnostic and Statistical Manual 4th ed., Revised
☐ GADS	Gilliam Aspergers Disorder Scale
☐ GARS-2	Giliam Autism Rating Scale
☐ M-CHAT	Modified Checklist for Autism in Toddlers
☐ PDDST-II	Pervasive Developmental Disorder Screening Test-II
☐ SCQ	Social Communications Questionnaire
☐ SRS	Social Responsiveness Scale
☐ STAT	Screening Tool for Autism in Two Year Olds

☐ Other, specify: _____

AUTISM HISTORY

Date First Diagnosed with Autism (Month/Day/Year)	Age Symptoms First Noted by Anyone
☐ Same as Today ☐ Unknown	_____ Yrs. _____ Mos. ☐ Unknown

SIBLING INFORMATION

Sibling Ages and Autism Diagnosis Status

☐ No Siblings

Sibling	Sibling Age Yrs.	Mos.	Unk.	Sibling Diagnosed with Autism Spectrum Disorder
1	_____	_____	☐	☐ Yes ☐ No
2	_____	_____	☐	☐ Yes ☐ No
3	_____	_____	☐	☐ Yes ☐ No
4	_____	_____	☐	☐ Yes ☐ No
5	_____	_____	☐	☐ Yes ☐ No
6	_____	_____	☐	☐ Yes ☐ No

EACH DIAGNOSED SIBLING SHOULD BE REGISTERED ON A SEPARATE FORM.

DIAGNOSTICIAN INFORMATION

Title	Name of Individual Making Diagnosis (Last, First)
☐ Dr. ☐ Mr. ☐ Ms.	

Highest Degree
☐ MD/DO ☐ Doctorate ☐ Master's ☐ Unknown

Specialty

☐ Education
☐ Family Practice
☐ Geneticist
☐ Neurology
☐ Neuropsychology
☐ Nursing
☐ Occupational Therapy
☐ Pediatrics-General
☐ Pediatrics-Specialty
☐ Physical Therapy
☐ Psychiatry
☐ Psychology
☐ Social Work
☐ Speech/Language Pathology
☐ Other, specify: _____
☐ Unknown

PRACTICE/FACILITY WHERE DIAGNOSIS MADE

Practice/Facility Name

Department/Unit

Street Address

Unit Description	Unit	P.O. Box

City	State

Zip Code	Country

Telephone Number ☐ No Phone

INFORMATION ON PERSON SUBMITTING REPORT

Relationship to Person Being Registered

☐ Diagnostician or Diagnostician's Staff
☐ Case Manager (SCHS, EI, CST, DDD, etc.)
☐ Other Health Care Provider
☐ Other, specify: _____

Title	Name (Last, First)
☐ Dr. ☐ Mr. ☐ Ms.	

CONTACT INFORMATION (IF DIFFERENT FROM DIAGNOSTICIAN)

Practice/Facility Name

Department/Unit

Street Address

Unit Description	Unit	P.O. Box

City	State

Zip Code	Country

Telephone Number ☐ No Phone