For use by CDD staff only:

Referral Date: ____________ CDD Client #: ____________
Intake Date: ________________

Child’s Name: ________________

How did you hear about the Parent Home Training Program?

__________________________________________________________________________________________________________________________________________________________

Where and when was your child diagnosed with an autism spectrum disorder?

__________________________________________________________________________________________________________________________________________________________

Family History

What languages are used in your child’s home?

__________________________________________________________________________________________________________________________________________________________

Who lives in your child’s home?

__________________________________________________________________________________________________________________________________________________________

Does anyone else regularly provide care for your child?

__________________________________________________________________________________________________________________________________________________________

Has your child recently been impacted by any of the following?

<table>
<thead>
<tr>
<th>Adoption</th>
<th>Y</th>
<th>N</th>
<th>Moving</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Illnesses</td>
<td>Y</td>
<td>N</td>
<td>Domestic Violence</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Foster Care</td>
<td>Y</td>
<td>N</td>
<td>Divorce</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Remarriage</td>
<td>Y</td>
<td>N</td>
<td>Substance Abuse</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Does anyone in the child’s immediate family have any developmental, mental health or psychiatric diagnoses?

__________________________________________________________________________________________________________________________________________________________
Services

Does your child currently receive educational/therapeutic services from any of the following?

<table>
<thead>
<tr>
<th>Service</th>
<th>Y</th>
<th>N</th>
<th>Name of Agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early intervention program</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>School program</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Other community service</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

What services does your child receive and how often do they receive them?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Current Concerns

How does your child currently communicate with you?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you have any concerns about your child’s behavior? If so, what are your concerns?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

How does your child play and get along with others?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Does your child display any sensory concerns? Does your child seem over or under responsive to certain stimuli?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you started toilet training yet?

______________________________________________________________________________
Are they any other concerns that you would like to share?


Medical

Does your child have any medical diagnoses other than an autism spectrum disorder?


Is your child currently on medication? (Please list)


Has your child ever had any of the following?

<table>
<thead>
<tr>
<th>Hospitalization</th>
<th>Y</th>
<th>N</th>
<th>Seizures</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Y</td>
<td>N</td>
<td>Significant Illnesses</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Injuries</td>
<td>Y</td>
<td>N</td>
<td>Vision problems</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Hearing problems</td>
<td>Y</td>
<td>N</td>
<td>Sleeping problems</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Eating problems</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe any items marked “Yes”:


Please send or scan and email your completed application to:

<table>
<thead>
<tr>
<th>University of New Mexico HSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Autism Programs Center for Development and Disabilities’ Division</td>
</tr>
<tr>
<td>Parent Home Training Program</td>
</tr>
<tr>
<td>2300 Menaul NE</td>
</tr>
<tr>
<td>Albuquerque, New Mexico 87107</td>
</tr>
</tbody>
</table>

Your family will be placed on the waiting list as soon as we receive your application, so please do not delay.

If you have any questions about this application or this program, please contact Sylvia J. Acosta 505-272-4725 or syacosta@salud.unm.edu