CENTER FOR DEVELOPMENT & DISABILITY

CDD Autism Transition and Adult Services Intake Checklist

Please complete as much of the intake packet as possible. We will need complete contact information for the client.

You may ask a family member, friend, or service provider to help complete the form. If any questions do not apply to you, please enter "NA". If you do not have the information to complete some sections, please leave those sections blank.

A member of our staff will contact you to review this intake and assist in gathering other information that might be useful in the evaluation. We may ask for consent to contact family or others who know you well, or worked with you in the past.

Please complete, sign, and return all of the following:

- ☐ CDD Autism Transition and Adult Services Intake Form (pages 2-6)
- ☐ UNMMG Consent to Treat - signed by the patient or legal guardian
- ☐ "About Me" Form
- ☐ UNMMG Telehealth consent forms - signed by the patient or legal guardian

We recommend that you keep this checklist, and a copy of the completed intake for your records.

How do I return completed forms?

1. Mail: Autism Spectrum Evaluation Clinic, UNM CDD, 2300 Menaul NE, Albuquerque NM 87107
2. Fax toll-free to (855) 294-1978
3. Call the Autism Spectrum Evaluation clinic at (505) 272-9337 for help with secure (encrypted) email communication

Please call the Autism Spectrum Evaluation Clinic, at (505) 272-9337 if you have any questions about evaluation services or this intake packet or if your contact information changes.

Autism Spectrum Evaluation Clinic
Transition and Adult Services Intake

Person completing form:	Relationship to client:
Date completed:	
Client Information	
Name:	
Date of birth:	
Address:	
Telephone: (home)	Telephone: (cell)
Telephone: (work)	e-mail
Please check preferred method of contact: ___*Home phone* ☐ *Cell phone* ___*e-mail* ☐ *Mail (USPS)*	
Signed consent from the patient or a legal guardian is required for clinic services. If there is an established legal guardian, or power of attorney for healthcare, please include documents with intake.	
Insurance Information *Medicaid coverage?* ☐*Yes / No* ☐ Medicaid #: _____ *Other insurance coverage?* ☐*Yes / No* ☐ Insurance company: _____ Group #: _____ Policy #: _____	
Parent, Caregiver, or legal guardian contact (if applicable)	
Name:	
Address:	
Telephone: (home)	Telephone: (cell /work)
	e-mail:
Please check preferred method of contact: ___*Home phone* ☐ *Cell phone* ___*e-mail* ☐ *Mail (USPS)*	

Who referred you for this evaluation?
Reason(s) for referral. *Please check all that apply.*
☐ Autism Spectrum Disorder (ASD) Diagnosis
☐ Behavioral Health
☐ Access to services (e.g., Disability Determination)
☐ Supports for employment or education
Please explain any other reasons you are seeking an Autism evaluation at this time:
Have you received a previous diagnosis of Autism Spectrum Disorder (including Autistic Disorder, Asperger's Disorder, PDD-NOS)? ☐ Yes ☐ No If yes, at what age? _____Who made this diagnosis?
Social History
List all languages you understand or use:
What do you consider your primary language?
Where are you currently living? ☐alone ☐ with spouse/partner ☐with parents ☐with other relatives ☐ with roommates/friends ☐supported housing (e.g., group home)
Accommodations. *Please describe any accommodations you may need to participate in an evaluation*

Health/Medical History		
Primary Care Provider Name	Mailing address	Contact #
		Phone
		Fax

Please list other any current or previous medical or behavioral health providers (e.g., counselor, psychiatrist, social worker, psychologist).	
Name / Discipline	Dates of care

Please list all medical diagnoses, who made the diagnosis and the date.		
Diagnosis	Given by	Date

Please list any mental health diagnoses (e.g., Depression, Anxiety), who made the diagnosis and the date it was made.		
Diagnosis	Given by	Date

Please check past or current medical concerns, and explain each checked area.
☐ Hospitalization
☐ Seizures
☐ Allergies
☐ Significant Illness
☐ Asthma or other breathing problems
☐ Injuries
☐ Visual Impairment
☐ Hearing Impairment
☐ Sleep Concerns
☐ Eating Concerns
☐ Stomach or bowel Problems
☐ Dental Problems
☐ Chronic Pain
☐ Other health issues

Educational History		
(check highest grade completed) ☐8th or under ☐9 ☐10 ☐11 ☐12 ☐ GED ☐ college or vocational training ☐ graduate degree		
Please list current and/or previous school districts and dates of attendance. Check if you had special education Individualized Educational Program (IEP).		
School District	Dates of attendance	IEP
		☐
		☐
		☐
		☐
		☐
Please list any other services/supports you received in school:		
Please include copies of any educational evaluations, and most recent Individualized Education Program (IEP), if applicable. If you do not have records, please list school districts and dates of any previous evaluations.		

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Center for Development and Disability
Consent to Treatment and Assignment of Benefits

1. I, the undersigned, hereby request and consent to medical treatment by the Center for Development and Disability or UNM Medical Group, Inc. and its physicians and staff (including administration of medication, tests and procedures) as deemed necessary.

2. I hereby assign and request payment directly to the Center for Development and Disability and UNM Medical Group, Inc. of any insurance or other authorized health benefits otherwise payable to me for medical treatment rendered, and to release any information required to the insurance company for consideration of payment for services.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Relationship to Patient

About Me

Your answers to these questions help us make sure we meet your needs and give the best, safest health care to **all** patients. Your answers will remain private. Access to this information is very restricted. Thank you!

What name do you want us to call you?

What is the sex on your original birth certificate?
☐ Male ☐ Female

Do you consider yourself Hispanic or Latino?
☐ Yes ☐
☐ Don't want to answe

What is your race? (Pick One)
☐ American India Alaska Nativ
☐ Asi
☐ Black or African Americ
☐ Native Hawaiian o other Pacific Island
☐ White or Angl

In what language do you prefer to talk about your health care? (Pick One)
☐ English
☐ Spanis
☐ Vietnamese
☐ Navajo
☐ American Sign Language
☐ Other

You have the right to a free interpreter. If needed, we'll provide one for you.

In what language do you prefer to read about your health care? (Pick One)
☐ English
☐ Spanish
☐ Vietnames
☐ Other
☐ I need help with readin

If you are American Indian/ Native American, what tribe(s) or pueblo(s)?
☐ Puebl
☐ Navaj
☐ Apache
☐ Other

What is your spiritual preference?
☐ Atheis
☐ Buddhis
☐ Catho
☐ Christian or Protestan
☐ Jehovah's Witnes
☐ Jewi
☐ Latter-Day Saints/Morm
☐ Mus
☐ Native
☐ Sikh
☐ Spiritual
☐ Other:
☐ No Preferenc

What is your relationship status?
☐ Single
☐ Legally married
☐ Domestic partnership/ civil union
☐ Partnered, living togethe
☐ Partnered, not living together
☐ Divorced/permanently separated
☐ Widowed/separated by deat
☐ Other

What is your current gender identity?
☐ Mal
☐ Femal
☐ Transgender Mal
☐ Transgender Femal
☐ Not completely ma or femal
☐ Other
☐ Don't want to answe

Do you think of yourself as:
☐ Straight or heterosexu
☐ Lesbian or ga
☐ Bisexu
☐ Other
☐ Don't
☐ Don't want to answe

Thank you!
If you have questions, please ask our staff.

patient label

What You Need to Know about Telehealth

What Is a Telehealth Visit?

A telehealth visit happens when you go to see your local provider. While you are there, the clinic uses a computer to connect to doctors and specialists at UNM in Albuquerque. The doctors at UNM might be connected with a live video and sound link. Or your provider might just send pictures and other information for those doctors to look at later.

This lets your provider work with doctors in other places to help you. But you don't have to travel to see them.

Why Do I Need a Telehealth Visit?

Your provider thinks it would be helpful to work with a health care specialist. The telehealth visit will allow you and your provider to work with a specialist.

How Can I Benefit?

- You can see a specialist who may help us understand your problem better.
- You might not need to go to Albuquerque.

How Is My Privacy Protected?

Your privacy is protected just like in a face-to-face visit.

- What you and the doctors say and see in live video visits happens on a special secure computer system. This means no one else can see or hear what's happening.
- We will do our best to keep your visit and results private. The specialist will only speak to your local provider unless you agree otherwise.
- Telehealth visits are not recorded.

What Are the Possible Risks?

- There could be problems with the computer connection. Then the UNM specialist may not be able to learn key things. Or the visit may have to be rescheduled.
- We are very careful to keep telehealth visits secure. But it is possible that our security could fail. If that happens, there is a chance your medical information may not stay private.

What Are My Rights with Telehealth Visits?

- You can stop the visit at any time. You just need to say you want to stop.
- Sometimes images are taken for the specialist to look at later. You can decide after the visit that you don't want them sent.
- You don't have to have more telehealth visits if you don't want to, even if your doctor thinks it would be a good idea.
- Even if you don't want any more telehealth visits, you may still see your regular provider. You may also ask to see the UNM specialist for a face-to-face visit.
- You have the right to be told of everyone who is in the room at the UNM clinic during live video visits. You also have the right to know about anyone who needs to come into the room. For example, if there is a problem with the computer, a technical person may need to come in to fix it. If you want to, you may leave the room until that person is gone. You may also ask a person to leave if you want them to.
- Your local providers will tell you about any talks they have with the specialist at UNM.
- You have the right to a copy of your medical records. You can get a copy by following the regular steps at your clinic or hospital.

What Else Should I Know?

- You or your insurance might be billed by UNM or your local provider for the visit. This will depend on agreements between your clinic and UNM. Ask your local clinic what to expect.
- Your local provider is still your main doctor. If you have an emergency or need to be seen right away, you should call your local provider.

Patient Consent for Telehealth Services

This form is to be used in addition to a consent for treatment appropriate to the service

Patient name _____ Date of birth _____

I have been given a copy of the handout "What You Need to Know about Telehealth," and I understand what it says.

I have had a chance to ask questions and they have been answered.

When I sign this form, I am saying I understand and agree that:

- the UNM health care specialist may discuss my medical history with my local provider.
- a provider at my local clinic may examine me as the UNM specialist guides him or her. The UNM specialist may also ask me questions through the video link.
- my medical information and images of my medical problems may be sent to the UNM specialist.

By signing below, I agree to use telehealth as part of my health care.

Patient Sign Here

Patient Sign Here _____ Date _____

If patient cannot sign, person who can legally give consent for patient.

Printed name of Authorized Signer _____ Relationship to Patient _____

Signature of Authorized Signer _____ Date _____

Witness Printed Name _____ Signature of Witness _____ Date _____

Referring Provider _____ Location _____

Consulting Provider _____ Location _____

patient sticker