



Preschool Autism Pre-assessment Form

INITIAL APPLICABLE BOXES

Child's Name:
Date of Birth: HSN:
Address:
City/Town: Postal Code:
Phone Number:

Date:
Site: Choose Autism Program
Referred by:

Form Completed By:
Other Site/Program:
Profession: Choose an item.
Other Profession:

Demographics and Referral Information

Name Child Goes by:
Child's Age:
Parent/Guardian:
Language:
Hearing:
Referral History and Information:
Parent/Guardian Questions or Concerns:
Medical, Family, and Developmental History:
Current Services Involved:
Please include any additional information or special considerations:

Information and Observation Method

Parent/Guardian Interview Choose an item.
Autism Specific Questionnaire/Interviews: Choose an item.
Autism Standardized Test or Observation Based Screen: Choose an item.
AMSE attached
Comments:



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Observations/Information Gathered in the Following Areas:

Communication:	Social Interaction:
Speech and Language:	Behaviours:
Motor Skills and Motor Mannerisms:	Safety:
Self-Care and Sleep:	Play:
Feeding:	Sensory and Regulation:
Overall Development:	
Other Information/Observations:	



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Follow-up/Recommended Assessment Level

Autism Assessment Recommended: Yes No Require Additional Information

Autism Assessment Level: Choose an item.

Assessment Comments:

Autism Program Location: Choose Autism Program

Other:

Parent/Guardian Consent and Plan

Plan: Choose an item.

Other plan:

Name of Parent/Guardian providing Consent:

Completed Referrals

Parent/Guardian consent obtained

Audiology Autism Services/Program (recommended): Choose Autism Program

Jordan's Principle Feeding Physiotherapy Social Work

Other:

Professional Name:

Signature: _____

Profession:

Contact Number:

Professional Name:

Signature: _____

Profession:

Contact Number:

Cc:

PowerPoint: Preschool Autism Pre-Assessment (CS-P-0009)

