

Clinician Confirmation of Diagnosis of Autism, Asperger’s Disorder, or Pervasive Developmental Disorder, Not Otherwise Specified (NOS)

Eligibility for Intensive In-Home Treatment Services under the Medicaid Home and Community Based Waiver Services requires a confirmed DSM-IV diagnosis of Autistic Disorder, Asperger’s Disorder, or Pervasive Developmental Disorder, NOS. You have conducted diagnostic evaluations and prepared a report which is being used to demonstrate eligibility for Intensive In-Home Services. Please confirm your diagnostic impressions below by indicating your findings and specific diagnosis of the individual indicated below.

Name of Child _____

Autistic Disorder	Asperger’s Disorder
<p>A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3)</p>	<p>A. Qualitative impairment in social interactions, as manifested by at least two of the following (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction <input type="checkbox"/> Failure to develop peer relationships appropriate to developmental level <input type="checkbox"/> Lack of spontaneous seeking to share enjoyment, interests, or achievements with others(e.g. by lack of showing, bringing, or pointing out objects of interest to others) <input type="checkbox"/> Lack of social or emotional reciprocity
<p>1. Impairment in social interaction as indicated by (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Impairment in use of multiple nonverbal behaviors such as eye contact, facial expressions, body posture, and gestures to regulate social interactions <input type="checkbox"/> Failure to develop peer relations appropriate to developmental level <input type="checkbox"/> Lack of spontaneous attempt to share enjoyment, interests, or achievements with others (e.g. does not show, bring, or point out objects of interest) <input type="checkbox"/> Lack of social or emotional reciprocity 	<p>B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following (check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity of focus <input type="checkbox"/> Inflexible adherence to specific, nonfunctional routines or rituals <input type="checkbox"/> Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements) <input type="checkbox"/> Persistent preoccupation with parts of objects

Autistic Disorder	Asperger's Disorder
<p>2. Qualitative communication impairments as indicated by (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Delay in or lack of development of spoken language (with attendant lack of compensatory communications such as gestures or mime) <input type="checkbox"/> If the individual has adequate speech, an impairment in the ability to initiate or sustain conversation <input type="checkbox"/> Stereotyped and repetitive language or idiosyncratic language <input type="checkbox"/> Lack of varied, spontaneous make-believe or social imitative play appropriate to developmental level 	<p>C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities as indicated by (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Preoccupation with one or more stereotyped and restricted patterns of interest of abnormal focus or intensity <input type="checkbox"/> Inflexible adherence to specific, nonfunctional routines or rituals <input type="checkbox"/> Stereotyped and repetitive motor mannerisms <input type="checkbox"/> Persistent preoccupation with parts of objects 	<p>D. There is no clinically significant general delay in language (e.g. single words used by age 2 years, communicative phrases used by age 3 years)</p> <ul style="list-style-type: none"> <input type="checkbox"/> No Clinically significant delay
<p>B. Delays or abnormal functioning in at least one of the following areas with onset prior to age 3: (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Social interaction <input type="checkbox"/> Language as used in social communication <input type="checkbox"/> Symbolic and imaginative play 	<p>E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood</p> <ul style="list-style-type: none"> <input type="checkbox"/> No clinically significant delay
<p>C. Rett's Disorder or Childhood Disintegrative Disorder does not better account for the disturbance</p> <ul style="list-style-type: none"> <input type="checkbox"/> Criteria are not met for Rett's Disorder or Childhood Disintegrative Disorder 	<p>F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia</p> <ul style="list-style-type: none"> <input type="checkbox"/> Criteria are not met for another PDD or schizophrenia

For a Pervasive Developmental Disorder, NOS, please indicate which of the criteria in the diagnostic categories above apply as well as additional symptoms supporting the diagnosis

Additional symptoms supporting PDD, NOS diagnosis:

Based on the above information, I assign the following diagnoses:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Name of Clinician (print name): _____

Signature of Clinician: _____

Date: _____