DELAWARE AUTISM SURVEILLANCE AND REGISTRATION

COMPLETE FORM ONLINE AND RETURN VIA MAIL OR FAX

AUTISM REGISTRY REPORTING FORM

Any case of an autism spectrum disorder (ASD) is reportable to the Delaware Autism Registry within one month of diagnosis. Follow-up reporting is due each year.

PATIENT INFORMATION

Child's Name: _____ (Last) _____ (First) _____ (MI) Date of Birth: ____/____/____ (MM/DD/YYYY)

Hospital of Birth: _____ Place of Birth: _____

Child's Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Phone: __(_____)_____

Race – check all that apply:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian: _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander: _____
- ☐ Other: _____

Ethnicity – Hispanic: ☐ Yes ☐ No

If Yes, please specify:

- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Parent/Legal Guardian (name): _____ (Last) _____ (First) _____ (MI)

Address (if different than child): _____ City: _____ State: _____ Zip: _____

Age symptoms first noted: _____ County and State of Residence at time of Diagnosis: _____

Current Medication(s) (please specify): _____

_____

Diagnosis

☐ Autistic Disorder ☐ Asperger's Disorder ☐ Pervasive Developmental Disorder ☐ Rett's Disorder

☐ Childhood Disintegrative Disorder ☐ Other (please specify): _____

Date of Diagnosis: _____ Co-morbidities: _____

DIAGNOSTICIAN INFORMATION

Name: _____ (Last) _____ (First) _____ (MI) _____ (Title)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _(____)_____ Fax: _(____)_____ Licensure Type: _____

Highest degree attained: _____ Year attained: _____

Specialty: _____ Subspecialty: _____

Facility where diagnosis was made:

- ☐ Private Practice (name): _____
- ☐ Specialty Clinic (name): _____
- ☐ Practice (name): _____
- ☐ Hospital (name): _____
- ☐ Other (name of facility): _____

Diagnostician Signature: _____ Reporting Date: _____

SUBMIT TO: Delaware Division of Public Health, Autism Surveillance System
Attention: Newborn Screening Program
417 Federal Street, Jesse Cooper Building, Dover, DE 19901
Phone: 1-800-262-3030 or (302) 744-4544 Fax: (302) 661-7227

Instructions for Completing the Delaware Autism Surveillance System Reporting Form

Please submit within one month of diagnosis and annually.

PATIENT INFORMATION

Child's name: last name, first name, middle initial

Date of Birth: child's date of birth**,** month/day/year

Hospital of Birth: name of hospital where child was born

Place of Birth: city, state where child was born

Child's address: street address, city, state, and zip code

Sex: check male or female

Phone number: area code and phone number

Race: check all that apply; fill in "other" if needed

Ethnicity: check Hispanic Yes, or No; If Hispanic Yes, check the origin listed, or fill in "other" if needed

Parent or legal guardian: last name, first name

Parent or legal guardian address: (if different than child's)

Age symptoms first noted: the age when the symptoms of an Autism Spectrum Disorder (ASD) were first noted by parent, caregiver or physician

County and State of Residence at time of Diagnosis: county and state where patient lived at time of diagnosis

Current Medication(s): list all medications that the patient is taking at the time of diagnosis

Diagnosis: Check confirmed diagnosis

Date of diagnosis: date on which the diagnosis of an ASD was made

Co-morbidities: list any other condition(s) that co-exists with the ASD

DIAGNOSTICIAN INFORMATION

Name: name of diagnostician: last name, first name, middle initial, title

Address: street address, city, state, and zip code

Phone number: area code and phone number

Fax number: area code and phone number

Licensure Type: type of licensure, if any, attained by diagnostician

Highest Degree and Year Attained: highest degree and year attained by diagnostician

Specialty: diagnostician area of specialty

Subspecialty: diagnostician area of subspecialty, if any

Facility where diagnosis was made: check type of facility and fill in name of facility where diagnosis was made

Diagnostician Signature: signature of the person/diagnostician who made the diagnosis

Reporting Date: date the diagnostician reporting form was filled out