

Neurodevelopmental Disorders Genetics Program, Mount Sinai (HSM 12-00798)

Date: _____ **Physician:** _____ **Hospital Center:** _____

Name of Patient: _____ **Date of Birth:** _____ **Gender:** F / M

Mount Sinai Use Only: _____ eCW _____ EPIC

Race: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Native American/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> Caucasian/White | <input type="checkbox"/> Other |
- Please Specify: _____

Is patient Hispanic or Latino?: Yes No

Diagnosis: (check all that apply)

Clinical Diagnosis	Age-Of-Onset	ICD 9/ICD 10 Code
<input type="checkbox"/> Autism Spectrum Disorder (ASD) <input type="checkbox"/> 1 Mild <input type="checkbox"/> 2 Moderate <input type="checkbox"/> 3 Severe Instruments/Tests used for ASD diagnosis: _____	_____ years _____ months	
<input type="checkbox"/> Epilepsy (Type: _____)	_____ years _____ months	
<input type="checkbox"/> Language Disorder (Type: _____)	_____ years _____ months	
<input type="checkbox"/> Non-Verbal (<i>Individuals ≥2 years old who use fewer than 5 words purposefully and meaningfully each day</i>)		
<input type="checkbox"/> Developmental Delay (Type: _____)		
<input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound	_____ years _____ months	
<input type="checkbox"/> Rett Syndrome-like (& MECP2-negative)	_____ years _____ months	
<input type="checkbox"/> Other (Please Specify: _____)	_____ years _____ months	

Previous Genetic Testing(s): Yes No

If Yes, please specify: _____

Previous Fragile X Mental Retardation 1 (FMR1) gene testing: Yes, Negative Yes, Positive No

Previous Intellectual functioning (IQ) testing: Yes, score: _____ No

Family history of neuro/psychiatric disorders: Yes No

If Yes, please specify: _____

Parent/Guardian Contact Information:

Phone _____ / _____

Mailing Address _____

DSM 5 Criteria: (check all that apply)

Underline the specific sign or symptom.		Add details; comment on level of impairment.
A: DEFICITS IN SOCIAL COMMUNICATION (MUST HAVE ALL 3)		
<input type="checkbox"/>	1. Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interactions.	
<input type="checkbox"/>	2. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated-verbal and nonverbal communication, through abnormalities in eye contact and body language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.	
<input type="checkbox"/>	3. Deficits in developing and maintaining relationships, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people.	
B: RESTRICTED, REPETITIVE PATTERNS OF BEHAVIOR (≥ 2)		
<input type="checkbox"/>	1. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypes, echolalia, repetitive use of objects, or idiosyncratic phrases).	
<input type="checkbox"/>	2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).	
<input type="checkbox"/>	3. Highly restricted, fixated interests that are abnormal in intensity or focus: (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests.	
<input type="checkbox"/>	4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).	

Circle Prominent Comorbid Symptom Domains:

Depression

Anxiety

OCD

(Hypo)mania

ADHD

Psychotic

PTSD

Learning Disability

Intellectual Disability (ID)

Cerebral Palsy

Other: _____

AUTISM MENTAL STATUS EXAM (CHECK ALL THAT APPLY)

EYE CONTACT (observed)	<input type="checkbox"/> ≥ 3 seconds	<input type="checkbox"/> Fleeting	<input type="checkbox"/> None	
INTEREST IN OTHERS (observed)	<input type="checkbox"/> Initiates Interaction with Examiner	<input type="checkbox"/> Only Passively Responds	<input type="checkbox"/> No Interest	
POINTING SKILLS (observed)	<input type="checkbox"/> Can Point/ Gesture to Object	<input type="checkbox"/> Only Follows Point	<input type="checkbox"/> None	
LANGUAGE (reported or observed)	<input type="checkbox"/> Can Speak About Another Time or Context	<input type="checkbox"/> Single Words <input type="checkbox"/> Phrases (≤ 3 words) <input type="checkbox"/> Undeveloped Sentences	<input type="checkbox"/> Nonverbal	
	<input type="checkbox"/> Articulation Problem			
PRAGMATICS OF LANGUAGE	<input type="checkbox"/> Not impaired <input type="checkbox"/> Not applicable	<input type="checkbox"/> Cannot manage turns or topics <input type="checkbox"/> Unvaried or odd intonation	<input type="checkbox"/> Reported <input type="checkbox"/> Observed	
REPTITIVE BEHAVIORS/ STEREOTYPY (reported or observed)	<input type="checkbox"/> None	<input type="checkbox"/> Compulsive behaviors/ Insists on Routines	<input type="checkbox"/> Motor mannerisms or verbal stereotypy <input type="checkbox"/> Echolalia <input type="checkbox"/> Stereotyped speech	
UNUSUAL OR ENCOMPASSING PREOCCUPATIONS	<input type="checkbox"/> None	<input type="checkbox"/> Present—describe:	<input type="checkbox"/> Reported <input type="checkbox"/> Observed	
UNUSUAL SENSITIVITIES	<input type="checkbox"/> None	<input type="checkbox"/> Heightened Sensitivity <input type="checkbox"/> High Pain Threshold	<input type="checkbox"/> Reported <input type="checkbox"/> Observed	