

## ***CSAAC's IEI Program*** **Clinic Application**

Please return this application, along with copies of the following materials on your child, if applicable, to:

CSAAC's IEI Program  
Attn: Brandi Best  
8615 East Village Ave Montgomery Village, MD 20866

Psychological Evaluation, Speech and Language Evaluation, Treatment reports/Workshop reports, Individualized Education Program, and Medical Evaluation reports (including physical exam and immunization records).

**ALL INFORMATION IS CONFIDENTIAL AND FOR CSAAC USE ONLY!**

### **1. Personal Information**

**Child's Name:** \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Circle one: Male / Female \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Home telephone: \_\_\_\_\_

Work telephone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Father's Address: \_\_\_\_\_

Home telephone: \_\_\_\_\_

Work telephone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Other Caretaker's  
Name(s): \_\_\_\_\_  
Contact information: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_

**2. Medical History**

Has your child been diagnosed with Pervasive Developmental Disorder, Autism, or other related condition? If yes, please provide information below and provide a copy of the most recent evaluation:

<u>Type of evaluation</u>	<u>Date</u>	<u>Evaluator</u>	<u>Institution</u>	<u>Diagnosis</u> (if any)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any significant medical conditions that your child has and name and phone of physician making diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any prescribed medications that your child is currently taking (long-term) or has taken in the past and indicated the name of the prescribing physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Please list all of your child's maintenance programs and indicate the date that the program was put on a maintenance schedule:

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2. Please list any other autism-related services that your child currently receives or has received in the past and indicated when the treatment began, the frequency, and duration of the treatment. Also indicated whether your child is still receiving the service:

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3. Has your child been referred and approved for funding in CSAAC's IEI Program by your county school administration? \_\_\_\_\_

School Contact person: \_\_\_\_\_

Phone: \_\_\_\_\_

4. If not, please indicate the steps, if any, you have taken to secure funding through your school district and the current status of funding for intensive early intervention:

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5. Does your child attend daycare, preschool, play group, or other part-time child care with other children? \_\_\_\_\_ If yes, please complete below:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Contact person: \_\_\_\_\_