Department of Communities Tasmania
Housing, Disability and Community Services
Tasmanian Autism Diagnostic Service
GPO Box 125
HOBART 7001

Department of Education
Students with Disabilities

Tasmania

Contact: Mary Jackson
Phone: (03) 61 661100
Fax: (03) 61 730439
E-mail: autismassessment@communities.tas.gov.au

Dear Parent/Guardian,

The Tasmanian Autism Diagnostic Service (TADS) provides comprehensive assessment for children and young people with possible autism spectrum disorders up to the age of 18 years. The assessment involves observation and interaction with the child, as well as an in-depth interview with parents regarding the child's developmental history, observations and concerns. There is no charge for the service.

The service requires children will have **at some point** been seen by a Paediatrician in relation to social or behavioural concerns. **If the child has not been seen by a Paediatrician in relation to social or behavioural concerns, please discuss a referral to a Paediatrician with your general practitioner.**

If you would like to proceed with a referral, the service requires some information prior to undertaking an autism assessment:

- ☐ Completion of the parents section
- ☐ Signed consent to undertake the autism assessment
- ☐ Please pass on the service provider questionnaire to your child's class teacher, day carer

Please note the parent section and signed consent are a priority for this referral to proceed to an appointment. It is our expectation this information will be returned to the service within 2 weeks upon receipt of this letter.

In addition to the above, the service requires a:

- ☐ Paediatrician's letter outlining social or behavioural concerns, including the results of any relevant medical or genetic tests if available. You may be able to contact your Paediatrician or GP to obtain a copy.

Copy of the most recent, if available:

- ☐ Cognitive, developmental or adaptive assessment, generally conducted by a Psychologist (privately or a School Psychologist)
- ☐ Speech pathology assessment
- ☐ Relevant reports: for example, Occupational Therapy assessments

If you do not have any of the above documents in your possession, please indicate where these could be obtained in the parent section. A pre-paid envelope (no stamp required) has been provided for return documentation.

If you require further information, please contact the service on 61661100.

Kind regards,

Ruth Mc Brien,
Manager/Senior Psychologist

Our Personal Information Protection Policy and Complaints Procedure are available upon request.

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Tasmanian Autism Diagnostic Service (TADS)
Parent/Carer/Guardian section (6 pages)

Child and Family Details

Child's Name: _____ Date of birth: ____/_____/____
(first name) (surname)

Male ☐ Female ☐

Name of Parent /Carer/Guardian: (1) Mr/Mrs/Ms/Miss _____
(first name) (surname)

Name of Parent /Carer/Guardian: (2) Mr/Mrs/Ms/Miss _____
(first name) (surname)

Occupation: (1)_____(2)_____

How many other children are there in the household? _____ Please list their ages _____

Address: _____ Telephone: (home) _____

_____Postcode: _____ (mob) _____

Email: _____

Name of child's GP: _____

Address: _____ Telephone: _____

_____Postcode: _____

Has the child been seen by a Paediatrician: ☐ Yes ☐ **No** ☐ My child has an appointment: Date___/___/____
(If **No** please contact the service)

Name of Paediatrician: _____

Address: _____ Telephone: _____

_____Postcode: _____

Cultural background (if not Australian): _____Interpreter Needed ☐
Please contact the service to discuss any religious or cultural concerns that may impact on the assessment.

Although the service is based in Hobart, regular regional clinics are conducted across the state.

Would you be willing to travel to Hobart for the assessment process? Yes ☐ No ☐

Would you be willing to stay overnight if required? Yes ☐ No ☐

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School or Child Care/Family Day Care Provider

Name of school or provider: _____ Grade: _____

Address: _____ Telephone: _____

_____Postcode: _____ Fax: _____

Email: _____

Contact Person: _____ Position: _____

Days attending:

Days	Monday	Tuesday	Wednesday	Thursday	Friday
Times attended					

List any other services or clinicians your child is currently accessing or has attended in the past:

Service	Location	Year/s	Referrer
Eg: ECIS, CAMHS	*Hobart*	*2008-2009*	*Dr Smith*

Has your child had any of the following assessments?

Assessment	Please circle	Date	Name & contact details
Psychological assessment, eg cognitive or developmental	Yes No		
Speech pathology assessment	Yes No		
Medical or genetic testing	Yes No		
Other, eg occupational therapy	Yes No		

Has your child ever had a formal hearing (audiology) assessment? YES ☐ NO☐
If yes, what were the results?

Do you believe your child's ***hearing*** is typical and has ***no difficulty hearing***? YES ☐ NO ☐
If you believe your child has difficulty hearing, please provide details

Do you believe your child's ***vision*** is typical and has ***no difficulty seeing***? YES ☐ NO ☐
If you believe your child has difficulty seeing, please provide details

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The following questions will provide TADS with preliminary information about your child.
Please answer these questions using examples where you can.

Early History

1. Was the pregnancy normal? Full term? Any complications?
☐ YES
☐ NO please provide details:

2. Were there any birth complications, e.g. foetal distress, lack of oxygen?
☐ NO
☐ YES please provide details:

3. Any serious illnesses, accidents, seizures or injuries, e.g. high fever, loss-of-consciousness?
☐ NO
☐ YES please provide details:

4. By 2 years did your child use single words meaningfully to communicate their needs and wants?
☐ YES
☐ NO

5. By 2 years was your child able to follow one-step instructions, e.g. "Get the ball"?
☐ YES
☐ NO

6. By 2 ½ years was your child able to share pretend play with another person, e.g. feeding dolls, playing garages, shops?
☐ YES
☐ NO

7. By 2 ½ years was your child able to use words or gesture to share their delight or interest with others, e.g. "See truck!"?
☐ YES
☐ NO

8. By 3 years did your child use phrase speech to communicate, e.g. "go to park", "I want juice"?
☐ YES
☐ NO

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Social Communication

1. Which of the following best describes your child's or young person's current speech/language abilities
   - ☐ Non verbal
   - ☐ Uses single words only
   - ☐ Uses short phrases, e.g. "I want drink", "Daddy go car", "Mummy come here"
   - ☐ Uses fluent speech and is able to talk about events that happened in the past or future e.g. "I went to the shop and bought a lolly", "Last week I got an award for spelling".

2. Does your child or young person only talk about a few topics?
   - ☐ NO
   - ☐ YES what are the topics?

3. Does your child or young person look at people when talking or listening to them?
   - ☐ YES
   - ☐ NO

4. Does the child or young person use gesture? e.g. pointing, beckoning someone to come, using their hands to indicate size or direction?
   - ☐ YES
   - ☐ NO

5. Does your child or young person show an interest in other children/peers, e.g. watching them, talking to you about them, interacting with them?
   - ☐ YES
   - ☐ NO

6. Does your child or young person prefer to play or be on their own rather than with others?
   - ☐ NO
   - ☐ YES

7. Does your child or young person regularly show and share their interests and achievements with others?
   - ☐ YES
   - ☐ NO

8. Does your child or young person seem aware of or interested in the feelings of others?
   - ☐ YES
   - ☐ NO please provide details:

9. Does your child or young person ever approach other people inappropriately? For example touching strangers, making inappropriate statements to other people.
   - ☐ NO
   - ☐ YES please provide details

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10. Does your child or young person spontaneously offer comfort to others if they are hurt, ill or distressed?
☐ YES
☐ NO please provide details:

Interests and Behaviour

1. Does your child or young person regularly repeat words, phrases or sentences exactly as they heard in the past? For example from other people or from the television. Does the child or young person ask repetitive questions?
☐ NO
☐ YES please provide details:

2. Does your child or young person have any special routines or things that they like to do in a particular way or order? For example pacing, a greeting ritual, an insistence on the same food or how food is eaten or presented.
☐ NO
☐ YES please provide details

3. Does your child or young person cope if their activities or routines are interrupted?
☐ YES
☐ NO please provide details:

4. Has your child or young person become preoccupied or obsessive about a particular object/subject or activity?
☐ NO
☐ YES please provide details

5. Does your child or young person regularly display any unusual physical mannerisms or repetitive body movements, e.g. hand flapping or flicking, spinning?
☐ NO
☐ YES please provide details

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6. Does your child or young person have any unusual sensory interests or reactions, e.g. sniffing books, over-sensitive to particular noises? Does your child or young person not react to differences in temperature (cold and heat) or to pain?

☐ NO
☐ YES please provide details

Please provide any additional concerns or comments you may have in the space below.

Checklist… have you

☐ Signed the consent form
☐ Completed the Parent section
☐ Provided the Service Provider Questionnaire to your child's school, child care or other service provider

and included the following reports if not provided previously:

☐ Letter from Paediatrician, outlining social or behavioural concerns

And if complete, please provide a copy of the most recent:

☐ Cognitive, adaptive, or developmental assessment
☐ Communication/speech and language assessment

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Parent/Guardian Consent

Child's Name: _____ D.O.B: _____

In accordance with the Personal Information Protection Act 2004 the Tasmanian Autism Diagnostic Service (TADS) will use your information to assist staff in completing accurate and comprehensive assessments, in providing suggestions and recommendations and evaluate the service provided. In order for the Tasmanian Autism Diagnostic Service to be able to provide a comprehensive assessment, report and recommendations for your child, we ask you consider consent to the following aspects of the service.

I _____ confirm I am the parent/legal guardian of _____,
(please print your name) (child's name)

and I give permission for the service to:

1. exchange information with the following other parent/guardians:

   Name of parent/carer/guardian: _____ Phone: _____

   Address: _____
2. conduct an autism assessment which may include observation of the child at school/child care
3. undertake any appropriate and relevant psychological and speech and language assessments
4. seek all relevant information about your child as required from schools & other educational & health services in relation to the assessment. Please list anyone who you do **NOT** want the service to contact:

   _____
5. maintain client records and collect statistical information from the client file to assist in service monitoring and planning.

TADS will make every effort to keep your details confidential. However, the service may be required by law to pass on information to other Government authorities. The team are mandatory reporters for the purposes of child protection and are required to report any child safety concerns or where a criminal offence is suspected. Except in these circumstances, the information received from you will not be made public and will only be used for the purposes for which it was collected.

I, as parent/guardian, understand the service will provide a report outlining the results of the assessment and that I will be a full participant in any and all decisions which might be made about my child.

Signed: _____ Today's date: _____
(parent/guardian)

This consent can be considered valid for 2 years, unless edited or revoked by the parent/guardian.

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Service Provider Questionnaire (4 pages)

To assist with our assessment, we would greatly appreciate you completing this questionnaire. This form is available for completion electronically and can be returned via an email attachment. For an electronic form, please send a request to autismassessment@communities.tas.gov.au

Please provide detailed information of **your observations** of the child, considering how they interact with you and peers (if applicable). Your observations and comments are a **critical component** of the assessment process.

Child's Name:	Service provider:
Name and title of person completing this questionnaire: ☐Mr ☐ Mrs ☐Ms ☐Miss	
Role (e.g. Teacher, Speech Therapist, Social Worker): How long have you worked with the child/young person?	
Phone Number:	Email:
Name of School Psychologist (if applicable):	Date:

Social Communication

1. Which of the following best describes this child's or young person's current speech/language abilities
☐ Non verbal
☐ Uses single words only
☐ Uses short phrases, e.g. "I want drink", "Daddy go car", "Mummy come here"
☐ Uses fluent speech and is able to talk about events that happened in the past or future e.g. "I went to the shop and bought a lolly", "Last week I got an award for spelling".

2. Does this child or young person have any particular friends or a best friend?
☐ YES - is the friendship mutual and reciprocal ☐ YES ☐ NO
☐ NO

3. Does this child or young person regularly show and share their interests and achievements with others?
☐ YES – do they monitor the other persons reaction ☐ YES ☐ NO
☐ NO

4. Does this child or young person spontaneously offer comfort to others if they are hurt, ill or distressed?
☐ YES
☐ NO

5. Does this child or young person have any difficulties with group work or cooperative play?
☐ NO
☐ YES please provide details

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6. Does this child or young person prefer to play or be with others of a different age?
☐ NO
☐ YES

7. Does this child or young person consistently respond to the approaches of others?
☐ YES
☐ NO

8. Does this child or young person make appropriate eye contact?
☐ YES
☐ NO

9. Does the child or young person use gesture e.g. pointing, beckoning someone to come, using their hands to indicate size or direction?
☐ YES – do they combine other types of non verbal behaviour? For example gesturing to indicate the presence of a preferred person with an excited facial expression. ☐ YES ☐ NO
☐ NO please provide details:

10. Does this child or young person show a range of subtle facial expressions? For example surprise, amusement and embarrassment
☐ YES
☐ NO

11. Can this child or young person read other people's body language? For example if a person points in a certain direction can they follow, can they tell others may be bored or annoyed, do they understand when someone gives them a stern look.
☐ YES
☐ NO

Interests, Behaviour and Skills

1. Does this child or young person regularly repeat words, phrases or sentences exactly as they have heard in the past? For example, from other people or from the television. Does the child or young person ask repetitive questions?
☐ NO
☐ YES please provide details

2. Does this child or young person display any strong or unusual interests?
☐ NO
☐ YES please provide details

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3. Does this child or young person have any special routines or things that they like to do in a particular way or order? For example pacing, a greeting ritual, an insistence on organizing items on their desk in a certain way?

☐ NO
☐ YES please provide details

4. Does this child or young person cope if their activities or routines are interrupted?

☐ YES
☐ NO please provide details:

5. Does this child or young person regularly display any unusual physical mannerisms or repetitive body movements, e.g. hand flapping or flicking, spinning?

☐ NO
☐ YES please provide details:

6. Does this child or young person have any unusual sensory interests or reactions, e.g. sniffing books, over-sensitive to particular noises? Does the child or young person not react to differences in temperature (cold and heat) or to pain?

☐ NO
☐ YES please provide details:

7. Does the child or young person focus on particular parts of objects? For example spinning wheels or lining up items or organising items according to size, colour, type or date.

☐ NO
☐ YES please provide details:

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Academics

1. How is the child or young person doing academically in comparison to peers (e.g., previous numeracy/literacy results)

requires significant curriculum adaptation ☐

below average ☐ average ☐ above average ☐

2. Child's or young person's relative strengths academically?

[a]

[b]

3. Child's or young person's academic challenges?

[a]

[b]

4. What are your 2 main concerns regarding this child or young person

[a]

[b]

5. Does the child or young person require additional supports within the classroom or playground?

☐ NO
☐ YES please provide details

Please provide any additional concerns or comments you may ha

Please note information provided on this form may be used within the diagnostic report

Please return the completed questionnaire to the child's parents, or to:
Tasmanian Autism Diagnostic Service

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