Clinical Services Intake Checklist

Please complete and include all of the following forms (include(620ir0038 4pt726)4 include(620

- UNMMG Consent to Treat - signed by leg
- “About Me” Form
- UNMMG Telehealth consent forms

If you have any screening reports, please inc

- Vision Screening
- Hearing Screening
- Developmental Screening (e.g., AS
- Autism Screening (e.g., M-CHAT-R

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Has the child received services or evaluation from any UNM Center for Development and Disability (CDD) Program in the past?

Check all that apply:	
• Early Childhood Evaluation Program (ECEP/Developmental clinic)	• Autism Parent Home Training
• Autism Spectrum Evaluation Clinic	• Child psychiatry (Dr. King)
• Fetal Alcohol Spectrum Disorder or Prenatal Exposures Clinic	• Neurodevelopmental Clinic
• Neurocognitive Assessment Clinic	• NM SAFE (Feeding)

Does the child have a sibling diagnosed with autism spectrum disorder? Yes No
If yes: Sibling Name: _____ Date of Birth: _____
Please include a copy of sibling's autism diagnostic evaluation report.

Develop mental Milestones

When did the child first do the following?	Age	Not yet	Not sure
Sit without help			
Crawl on hands and knees			
Walk without help			
Say single words			
Combine two words			
Talk in short sentences			

Toilet trained: • daytime • overnight

What You Need to Know about Telehealth

What Is a Telehealth Visit?

I have been given a copy of the handout
“What You Need to Know about Telehealth,” and I understand what it says.

I have had a chance to ask questions and they have been answered.

When I sign this form, I am saying I understand and agree that:

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Patient Sign Here

Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: Medical Record #:

Patient Name:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH