

## **The Kelly O’Leary Center**

for Autism Spectrum Disorders  
Cincinnati Children’s Hospital Medical Center

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### ***Community Consultation Program***

***Supported by Hamilton County Board of MR/DD***

Thank you for your interest in the Community Consultation Program. The Kelly O’Leary Center (TKOC) provides support to teams serving children with autism spectrum disorders in a variety of areas including behavior, education/skill acquisition, communication, and self-regulation. These supports may include direct and indirect consultation, functional behavioral analysis, curriculum modification, environmental supports, review of objectives and teaching methods, modeling of intervention techniques, and team training.

If the team is interested in pursuing collaborative consultative services with TKOC, please complete and return the following information:

- 1) School Questionnaire
- 2) Copy of the most recent IEP/MFE
- 3) Documentation of autism spectrum diagnosis, if not on IEP/MFE
- 4) Parent Questionnaire
- 5) 2 Parent Consent Forms

Once the intake file is complete a consultant will be assigned. The consultant will contact the school liaison to set up an initial observation/team meeting. If you have any questions regarding the enclosed information or the referral/intake process, please do not hesitate to call. We look forward to working with your team.

Sincerely,

Melissa A. Foti Hoff, Psy.D.  
Coordinator of Community Consultation  
The Kelly O’Leary Center

Donna Murray, Ph.D.  
Director of Treatment  
The Kelly O’Leary Center

**Please note NEW program contact information, return forms to:**

**Ellen Allgeier, Customer Service Representative**

The Kelly O’Leary Center for ASD  
Children’s Hospital Medical Center  
MLC 6015  
5642 Hamilton Ave  
Cincinnati, Ohio 45224

**Email:** [ellen.allgeier@cchmc.org](mailto:ellen.allgeier@cchmc.org) BEFORE August 26, 2009 please also Cc:

[jan.richards@cchmc.org](mailto:jan.richards@cchmc.org)

**Phone:** 513 636-1760

**Fax:** 513 636-1759



THE KELLY O'LEARY CENTER FOR AUTISM SPECTRUM DISORDERS (TKOC)  
DIVISION OF DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS  
CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER

MLC 6015, 5642 Hamilton Ave., Cincinnati, OH 45224 (513)636-1760 Fax: (513)636-1759

COMMUNITY CONSULTATION PROGRAM  
SCHOOL QUESTIONNAIRE  
2009-2010

Please note: This form is to be completed by the referring school staff. In order to avoid duplication of services, TKOC does not consult to teams who are already receiving consultation from another outside agency. If you feel there are extenuating circumstances which justify TKOC involvement, please contact the Coordinator of Community Consultation before completing a referral.

IDENTIFYING INFORMATION:

Student's Name: \_\_\_\_\_

First Middle Last

Student's preferred name: \_\_\_\_\_ Student's SS#: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Student's grade: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Alternate: ( ) \_\_\_\_\_

Name(s) of Legal Guardian(s): \_\_\_\_\_ Relationship(s) to Child: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Alternate: ( ) \_\_\_\_\_

Alternate Contact Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

ELIGIBILITY:

In order to qualify for TKOC Community Consultation Services the student must have a diagnosis within the autism spectrum. Please indicate the student's diagnosis and attach clear documentation of this diagnosis (e.g., documentation of diagnosis on the IEP/MFE, physician/psychologist evaluation report or letter etc.):

\_\_\_\_\_ Autism \_\_\_\_\_ Asperger's \_\_\_\_\_ PDD-NOS \_\_\_\_\_ Autism Spectrum Disorder

\_\_\_\_\_ Educational Classification of Autism on IEP/MFE

EDUCATIONAL INFORMATION:

School: \_\_\_\_\_ School District: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Hours: \_\_\_\_\_

Primary Teacher: \_\_\_\_\_ Principal/Supervisor: \_\_\_\_\_

Speech/Language Pathologist: \_\_\_\_\_ Occupational Therapist: \_\_\_\_\_

*Please identify the primary contact person for this referral:*

Contact Person: \_\_\_\_\_ Position: \_\_\_\_\_

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

PRIMARY REFERRAL CONCERN(S):

Briefly describe the student's daily schedule at school including educational placement(s):

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Briefly describe the student's communication skills including current communication system(s):

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Briefly describe the child's typical behavior in the classroom and attitude towards classmates and teacher:

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How does this student interact with staff and peers:

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How does he/she handle anger or frustration?

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Briefly describe behaviors of particular concern:

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Briefly describe any strategies attempted to address these behavioral concerns (attach behavior plan if applicable):

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Describe the student's strengths:

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**CHECK ITEMS BELOW THAT ARE CURRENTLY OF CONCERN:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Poor motor coordination (clumsy) | <input type="checkbox"/> Overly sad                   | <input type="checkbox"/> Fights with other children    |
| <input type="checkbox"/> Does not hear well               | <input type="checkbox"/> Cries frequently             | <input type="checkbox"/> Destructive                   |
| <input type="checkbox"/> Does not see well                | <input type="checkbox"/> Problems with peer relations | <input type="checkbox"/> Temper tantrums               |
| <input type="checkbox"/> Does not talk                    | <input type="checkbox"/> Overactive                   | <input type="checkbox"/> Takes others belongings       |
| <input type="checkbox"/> Does not understand speech       | <input type="checkbox"/> Short attention span         | <input type="checkbox"/> Untruthful                    |
| <input type="checkbox"/> Stutters                         | <input type="checkbox"/> Confuses left and right      | <input type="checkbox"/> Inappropriate sexual behavior |
| <input type="checkbox"/> Drools                           | <input type="checkbox"/> Not learning in school       | <input type="checkbox"/> Masturbates                   |
| <input type="checkbox"/> Problems with weight             | <input type="checkbox"/> Poor social boundaries       | <input type="checkbox"/> Interested in violent themes  |
| <input type="checkbox"/> Mouths objects                   | <input type="checkbox"/> Bites nails, self, others    | <input type="checkbox"/> Experiments with fire         |
| <input type="checkbox"/> Feeding problems                 | <input type="checkbox"/> Poor eye contact             | <input type="checkbox"/> Uncooperative                 |
| <input type="checkbox"/> Eats paint, putty, plaster, dirt | <input type="checkbox"/> Rocks                        | <input type="checkbox"/> Wets bed                      |
| <input type="checkbox"/> Hand flaps                       | <input type="checkbox"/> Lacks toilet training        | <input type="checkbox"/> Spins                         |
| <input type="checkbox"/> Poor sleeper                     | <input type="checkbox"/> Lines up objects             | <input type="checkbox"/> Worries/Anxiety               |
| <input type="checkbox"/> Bangs head                       | <input type="checkbox"/> Fearfulness                  | <input type="checkbox"/> Lost any skills               |
| <input type="checkbox"/> Moody                            | <input type="checkbox"/> Prefers to be alone          | <input type="checkbox"/> Other _____                   |

CONSULTATION GOALS:

What does the team want to specifically address during this consultation process?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

ADDITIONAL COMMENTS:

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Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Principal/Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Briefly describe any behaviors of particular concern at home and/or school:

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Briefly describe any strategies attempted to address these behavioral concerns:

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Does your child have any sensory sensitivities?

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List your child's most preferred activities/items. This may include toys, food, sensory items etc.

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Describe your child's strengths:

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**INDICATE ITEMS BELOW THAT ARE CURRENTLY OF CONCERN AT HOME (H) and/or SCHOOL (S):**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Poor motor coordination (clumsy) | <input type="checkbox"/> Overly sad                   | <input type="checkbox"/> Fights with other children    |
| <input type="checkbox"/> Does not hear well               | <input type="checkbox"/> Cries frequently             | <input type="checkbox"/> Destructive                   |
| <input type="checkbox"/> Does not see well                | <input type="checkbox"/> Problems with peer relations | <input type="checkbox"/> Temper tantrums               |
| <input type="checkbox"/> Does not talk                    | <input type="checkbox"/> Overactive                   | <input type="checkbox"/> Takes others belongings       |
| <input type="checkbox"/> Does not understand speech       | <input type="checkbox"/> Short attention span         | <input type="checkbox"/> Untruthful                    |
| <input type="checkbox"/> Stutters                         | <input type="checkbox"/> Confuses left and right      | <input type="checkbox"/> Inappropriate sexual behavior |
| <input type="checkbox"/> Drools                           | <input type="checkbox"/> Not learning in school       | <input type="checkbox"/> Masturbates                   |
| <input type="checkbox"/> Problems with weight             | <input type="checkbox"/> Poor social boundaries       | <input type="checkbox"/> Interested in violent themes  |
| <input type="checkbox"/> Mouths objects                   | <input type="checkbox"/> Bites nails, self, others    | <input type="checkbox"/> Experiments with fire         |
| <input type="checkbox"/> Feeding problems                 | <input type="checkbox"/> Poor eye contact             | <input type="checkbox"/> Uncooperative                 |
| <input type="checkbox"/> Eats paint, putty, plaster, dirt | <input type="checkbox"/> Rocks                        | <input type="checkbox"/> Wets bed                      |
| <input type="checkbox"/> Hand flaps                       | <input type="checkbox"/> Lacks toilet training        | <input type="checkbox"/> Spins                         |
| <input type="checkbox"/> Poor sleeper                     | <input type="checkbox"/> Lines up objects             | <input type="checkbox"/> Worries/Anxiety               |
| <input type="checkbox"/> Bangs head                       | <input type="checkbox"/> Fearfulness                  | <input type="checkbox"/> Lost any skills               |
| <input type="checkbox"/> Moody                            | <input type="checkbox"/> Prefers to be alone          | <input type="checkbox"/> Other _____                   |

**SLEEP:**

What time does your child typically go to sleep? \_\_\_\_\_ What time does your child typically awaken? \_\_\_\_\_  
Does your child have any sleep difficulties that the TKOC consultant should be aware of? \_\_\_\_\_

**MEDICATIONS:**

Is your child currently taking any medications? \_\_\_\_\_ If yes, please list below:

<b>Medication</b>	<b>Purpose</b>	<b>Prescribing Physician</b>

**ALLERGIES:**

Does your child have any allergies or dietary restrictions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL COMMENTS:**

Please provide any further information that you feel is important in order for TKOC consultant to understand and work with you child and school team:

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

**COMMUNITY SERVICE PROVIDERS:**

If your child has a service provider(s) within or outside of CCHMC that you would like to be directly notified of his/her involvement with TKOC Community Consultation Program please identify the provider(s) below. The identified provider(s) will be sent a letter stating *only* that your child is receiving services through TKOC Community Consultation Program. Please be aware that a release of information will be needed for any further communication.

Service Providers Name: \_\_\_\_\_  
Title/Role: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Service Providers Name: \_\_\_\_\_  
Title/Role: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Service Providers Name: \_\_\_\_\_  
Title/Role: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Service Providers Name: \_\_\_\_\_  
Title/Role: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by:

Parent/guardian (Print Name): \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Please return this form either to the referring school team or directly to TKOC at the address listed at the top of this questionnaire (ATTN: Coordinator of Community Consultation). Your child's referral cannot be processed until all paperwork is completed.

**The Kelly O'Leary Center for Autism Spectrum Disorders (TKOC)**  
**Division of Developmental and Behavioral Pediatrics**  
**Cincinnati Children's Hospital Medical Center**  
**Community Consultation Team**  
**2009-2010**

Your child has been referred by his/her school/agency for Community Consultation services at The Kelly O'Leary Center for Autism Spectrum Disorders (TKOC)/Division of Developmental and Behavioral Pediatrics of Cincinnati Children's Hospital Medical Center.

The purpose of this consultation is to offer the professionals who work with your child new ideas and insights into meeting your child's unique needs. A consultant will observe your child in the community setting, review records, model intervention strategies, and meet with his/her team to discuss concerns regarding educational, communicative, self-regulation, and behavioral issues. The information gathered may also be presented at The Kelly O'Leary Center's multi-disciplinary team meetings in order to gain clinical expertise from various fields including Psychology, Pediatrics/Nursing, Speech, and Occupational Therapy. The goal is to obtain a comprehensive picture of your child's strengths and weakness in order to explore areas which may respond to intervention and then work with your child's team to develop a plan.

As a vital part of your child's intervention team, parents are involved in providing important information regarding your child's needs. Your input allows us to provide suggestions that are geared to your child's individual needs. Parent interviews can be completed by phone or at team meetings scheduled by your child's school/agency. Parents/guardians may obtain a copy of TKOC behavioral policies and procedures by contacting The Kelly O'Leary Center at (513) 636-1760.

Since these services are funded by the Hamilton County Board of MR/DD, your child's name and eligibility information will be entered into the MR/DD system at the local and state level. Signing this consent form gives permission for the Hamilton County Board of MR/DD to access, record, and review this information. The Kelly O'Leary Center shall permit the HCB of MR/DD, upon reasonable request, to have access to any and all information, including, but not limited to, books, accounts, records, audit reports and other pertinent information which is necessary, in the discretion of HCB of MR/DD, to audit costs related to the operation of The Kelly O'Leary Center under this agreement.

**Information:**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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

\_\_\_\_\_

Telephone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Other): \_\_\_\_\_

Child's School/agency Name: \_\_\_\_\_

Child's School District: \_\_\_\_\_

**Authorization:**

I (parent/guardian name) , \_\_\_\_\_, acknowledge by my signature below that I understand the information presented above regarding the nature and purpose of the consultation services being requested by my child's school/agency.

As the parent/guardian of (child's name), \_\_\_\_\_,

I give permission to The Kelly O'Leary Center/Division of Developmental and Behavioral Pediatrics to provide consultative services to (child's school/agency) \_\_\_\_\_

and (child's school district) \_\_\_\_\_, on behalf of my child.

I agree to share my child's name and eligibility information with the Hamilton County Board of MR/DD in order to participate in this program. I understand that the recommendations made by The Kelly O'Leary Community Consultation Team are not legally binding to myself, the school/agency, Hamilton County Board of MR/DD, or Cincinnati Children's Hospital Medical Center.

I consent to the release and exchange of information/records with The Kelly O'Leary Center and the above designated school/agency and school district.

I also consent to the release and exchange of information and review of records within The Kelly O'Leary Center/Division of Developmental and Behavioral Pediatrics at Cincinnati Children's Hospital Medical Center.

This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the health Information management department, 513- 636-8233.

CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The Kelly O'Leary Center for Autism Spectrum Disorders (TKOC)**  
**Division of Developmental and Behavioral Pediatrics**  
**Cincinnati Children's Hospital Medical Center**  
**Community Consultation Team**  
**2009-2010**

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

Child's DOB: \_\_\_\_\_

Child's SS#: \_\_\_\_\_

Due to the nature of the program, services that your child receives through The Kelly O'Leary Center's Community Consultation Team are documented *separate* from the Cincinnati Children's Hospital Medical Center (CCHMC) medical record. Therefore, if your child is a patient at CCHMC his/her doctor(s)/provider(s) do not automatically have access to records regarding TKOC community consultation. In order to assist in collaboration between TKOC staff and other CCHMC providers, you may choose to have this form sent to your child's permanent CCHMC medical record and/or your child's permanent CCHMC *Division of Developmental and Behavioral Pediatrics* medical record to document that your child is receiving community consultation services from TKOC and to document that there is a separate chart for your child in TKOC.

\_\_\_\_\_ I consent to have this form sent to my child's permanent CCHMC medical record to document that my child is receiving community consultation services through TKOC and to document that there is a separate chart for my child in TKOC.

\_\_\_\_\_ I consent to have this form sent to my child's permanent CCHMC *Division of Developmental and Behavioral Pediatrics* medical record to document that my child is receiving community consultation services through TKOC and to document that there is a separate chart for my child in TKOC.

\_\_\_\_\_ I do not consent to have this form sent to my child's permanent CCHMC medical record to document that my child is receiving community consultation services through TKOC and to document that there is a separate chart for my child in TKOC.

\_\_\_\_\_ I do not consent to have this form sent to my child's permanent CCHMC *Division of Developmental and Behavioral Pediatrics* medical record to document that my child is receiving community consultation services through TKOC and to document that there is a separate chart for my child in TKOC.

In addition:

\_\_\_\_\_ In the event of an emergency, I authorize the release of additional information as deemed clinically necessary to other CCHMC providers. During non-emergency situations or to persons outside of CCHMC, I understand my written authorization is needed to release any information to another source.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_