DDSN Autism Division
Request for Consultation and Needs Assessment

Consumer's Name:_____ Consumer's Date of Birth: ___ _____

Consumer's Address: _____

Name of Person/Agency Making Request: _____ Date of Request:_____

Relationship of Person/Agency Making Request to Consumer: _____

Contact Information for Person/Agency Making Request:

- Address: _____
- Phone Number:_____
- Email Address: _____

Please answer the following questions to assist us in identifying the best way to provide you with meaningful and timely support for the consumer.

1. Please describe the consumer's strengths and interests: _____
_____

2. Please describe the things that currently work well for you and the consumer:
_____
_____

3. What are the top 3 concerns that you would like assistance with for the consumer?
1. _____
2. _____
3. _____

4. Please rate your need for support in each area listed below by checking the appropriate box.

	I do not need support in this area.	I am unsure if I need support in this area.	This area is a low priority.	This area is a high priority.
General Information and Accessing Services				
Basic information about ASD				
How to access ABA				
How to access other therapies (e.g., speech)				
How to access other services (respite care, child care, support groups, dentist)				
How to access case management or early intervention (Medicaid, Social Security, etc)				
Interacting with siblings and other family members				
Health and Safety Strategies at home/community				

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	I do not need support in this area.	I am unsure if I need support in this area.	This area is a low priority.	This area is a high priority.
General information about education/school				
Advocacy and life- long planning				
Challenging behaviors				
Communication (expressing basic wants/needs)				
Daily living skills (eating, dressing, toileting)				
Social skills (playing, sharing, having conversations)				
Community skills (playground, restaurant, store)				
Collaboration between home and school				

If you have concerns about challenging behaviors, please check which of the following the consumer engages in, how often each occurs and the severity of each.

Behavior	**How often does the behavior occur?**	**How severe is the behavior when it happens?**
❑ **Aggression (hitting, biting, kicking others)**	❑ **daily** ❑ **weekly** ❑ **monthly**	❑ **mild** ❑ **moderate** ❑ **severe**
❑ **Self-Injury (head banging, biting)**	❑ **daily** ❑ **weekly** ❑ **monthly**	❑ **mild** ❑ **moderate** ❑ **severe**
❑ **Tantrums**	❑ **daily** ❑ **weekly** ❑ **monthly**	❑ **mild** ❑ **moderate** ❑ **severe**
❑ **Non-compliance (saying no, ignoring directions)**	❑ **daily** ❑ **weekly** ❑ **monthly**	❑ **mild** ❑ **moderate** ❑ **severe**
❑ **Other _____**	❑ **daily** ❑ **weekly** ❑ **monthly**	❑ **mild** ❑ **moderate** ❑ **severe**

5. Is there anything else that you would like assistance with related to the consumer?

_____

_____

****You can view the Autism Division Training Calendar here:**
http://www.ddsn.sc.gov/consumers/divisions/Pages/Autism.aspx

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Signature of Person Making Request: _____ Date:_____

Name of Person Making Request (please print): _____

Title of Person Making Request (if applicable): _____

Signature of Consumer (if 18 years old or over): _____

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For office use only:

Date Request Received: _____ Date Contact Made with Family: _____

Date Waiting List Letter sent: _____ Record of Contact completed:_____

Initial Tier Placement (check):

☐1 (online trainings) ☐2 (phone call) ☐3 (in-person) ☐4 (PBS- Central Office) ☐NA (no action- state why)

No Action Response:

_____

_____

Consultant Assigned: _____