

Dear Physician,

In order to provide services to your patient, _____ dob _____, it is necessary that we have a diagnostic report outlining the behavioral observations or other tests that you have performed in making a diagnosis on the autism spectrum. For purposes of clarification, the Florida CARD definition of Autism Spectrum Disorders includes Autistic Disorder, Pervasive Developmental Disorder-Not Otherwise Specified, Asperger's Disorder, Rett's Disorder and Childhood Disintegrative Disorder.

In lieu of a detailed report, please complete the checklist below:

Instruments Used (please check all used)

	ADOS		ADI-R		CHAT/MCHAT/PEDS		STAT/BITSEA
	GADS/ASDS/CAST/KADI		CARS/GARS		ABC		PDD-BDI
	Ages&Stages/CSBS		DSM-IV Criteria		None		Other:

Your diagnosis is based on observing which of the following diagnostic indicators (check all that apply)

<input type="checkbox"/>	marked impairment in the use of multiple nonverbal behaviors such as ___ eye-to-eye gaze, ___ facial expression, ___ body postures, and ___ gestures to regulate social interaction
<input type="checkbox"/>	absence of peer relationships appropriate to developmental level
<input type="checkbox"/>	a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
<input type="checkbox"/>	lack of social or emotional reciprocity
<input type="checkbox"/>	delay in, or total lack of, the development of spoken language
<input type="checkbox"/>	in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
<input type="checkbox"/>	stereotyped and repetitive use of language or idiosyncratic language
<input type="checkbox"/>	lack of varied, spontaneous make-believe play or social imitative play
<input type="checkbox"/>	restricted patterns of interest that are abnormal either in intensity or focus
<input type="checkbox"/>	inflexible adherence to specific, nonfunctional routines or rituals
<input type="checkbox"/>	stereotyped and repetitive motor manners (e.g., hand or finger flapping or twisting, or complex whole-body movements)
<input type="checkbox"/>	persistent preoccupation with parts of objects
<input type="checkbox"/>	delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
<input type="checkbox"/>	clinically significant impairment in social, occupational, or other important areas of functioning.
<input type="checkbox"/>	no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.
<input type="checkbox"/>	Age-appropriate onset of language (50 words by age 2; short phrases and sentences by age 3)
<input type="checkbox"/>	Criteria are not met for Schizophrenia.

Your diagnosis is: (please use DSM-IV categories): _____

Please check here if you did NOT diagnose this patient with an autism spectrum disorder:

Your name: _____ Signature or Stamp: _____

Thank you. Please fax to 407 823 6012 or mail to: UCF CARD, PO Box 162202, Orlando, FL 32816-2202