Dear Parent/Guardian/Patient:

So that we may provide the best care at the Glickman Lauder Center of Excellence in Autism and Developmental Disorders, please complete this Care Excellence Information form.

Patient's legal name: _____DOB:_____

Patient's nickname?: _____
Patient's pronoun(s) (he/she/they/other): _____

Communication (check all that apply):
___ Fully Verbal
___ Minimally Verbal (mainly scripting / echolalia)
___ Non-Verbal
___ Uses Assistive Communication (**circle all that apply:** PECS, picture board, sign language, device/tablet)

Vision concerns? Yes/No Wears glasses? Yes/No
Hearing concerns? Yes/No Uses hearing aids? Yes/No

Sensory sensitivities (circle all that apply: noise, touch, sound, light, cold, hot)
Please explain: _____

How long can patient tolerate an appointment? _____

What can we do to make the appointment go well? _____

What are the patient's interests? _____

Recommendations on handling challenging moments:

Please bring this form with you when you come for your next appointment, or mail/fax it to us at the address below:

Glickman Lauder Center of Excellence in Autism and Developmental Disorders

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Portland, ME 04102

Fax: (207) 761-0783