

Autism Spectrum Disorder Diagnostic Confirmation

Required for children diagnosed prior to July 1, 2015 that were diagnosed without using the ADOS, ADOS-2, ADI-R or the PL-ADOS

Date of first Autism Spectrum Disorder diagnosis:

Name and credentials of provider:

Describe tools/process used for establishing diagnosis:

Diagnostic criteria met according to

___ medical records documentation and / or ___ current examination
(check all that apply and provide examples):

All indicators must be met in this section.

- ___ **A1. Deficits in social emotional reciprocity**
if present, provide example:
- ___ **A2. Deficits in non-verbal communicative behaviors related to social interaction**
if present, provide example:
- ___ **A3. Deficits in developing, maintaining, and understanding relationships**
if present, provide example:

Two of the four indicators must be met in this section.

- ___ **B1. Stereotyped or repetitive motor movements**
if present, provide example:
- ___ **B2. Insistence on sameness**
if present, provide example:
- ___ **B3. Highly restricted interests**
if present, provide example:
- ___ **B4. Hyper or Hypo reactivity to sensory input**
if present, provide example:

All indicators must be met in this section.

- ___ **C. Symptoms were present in early development**
- ___ **D. Symptoms cause significant impairments in daily functioning**
- ___ **E. Symptoms are not better explained by intellectual disability**

Choose one:

- ___ Documentation from first diagnostic assessment enclosed or
- ___ No prior documentation available (must include explanation as to why records are not available)

My examination of this patient confirms the previous diagnosis of Autism Spectrum Disorder.

Signature and Credentials of Certifying Provider

Date