

PEDIATRIC CARE OF KENTUCKY, P.S.C.

Dear Parent(s):

The form on the reverse side of this paper is a screening tool for autism in toddlers, recommended by the American Academy of Pediatrics as standard of care, which is call the M-CHAT.

This form will be requested to be completed by the parent (s) during the child's 18-month and 24-month appointment.

Effective 6-19-08: There is a charge for the physician's evaluation of this form which will be billed to your insurance company. This charge is covered by most insurance plans, but depending on your individual coverage could result in patient responsibility.

Modified Checklist for Autism in Toddlers (M-CHAT)

Patient Name: _____ DOB: _____ Date of test: _____ Historian: _____ Relationship to child: _____

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|-----|----|-----|--|
| Yes | No | 1) | Does your child enjoy being swung, bounced on your knee, etc.? |
| Yes | No | 2) | Does your child take an interest in other children? |
| Yes | No | 3) | Does your child like climbing on things, such as upstairs? |
| Yes | No | 4) | Does your child enjoy playing peek-a-boo/hide - and - seek? |
| Yes | No | 5) | Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things? |
| Yes | No | 6) | Does your child ever use his/her index finger to point, to ask for something? |
| Yes | No | 7) | Does your child ever use his/her index finger to point, to indicate interest in something? |
| Yes | No | 8) | Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling or dropping them? |
| Yes | No | 9) | Does your child ever bring objects over to you (parent) to show you something? |
| Yes | No | 10) | Does your child look you in the eye for more than a second or two? |
| Yes | No | 11) | Does your child ever seem oversensitive to noise? (e.g., plugging ears) |
| Yes | No | 12) | Does your child smile in response to your face or your smile? |
| Yes | No | 13) | Does your child imitate you? (e.g., you make a face-will your child imitate it?) |
| Yes | No | 14) | Does your child respond to his/her name when you call? |
| Yes | No | 15) | If you point at a toy across the room, does your child look at it? |
| Yes | No | 16) | Does your child walk? |
| Yes | No | 17) | Does your child look at things you are looking at? |
| Yes | No | 18) | Does your child make unusual finger movements near his / her face? |
| Yes | No | 19) | Does your child try to attract your attention to his / her own activity? |
| Yes | No | 20) | Have you ever wondered if your child is deaf? |
| Yes | No | 21) | Does your child understand what people say? |
| Yes | No | 22) | Does your child sometimes stare at nothing or wander with no purpose? |
| Yes | No | 23) | Does your child look at your face to check your reaction when faced with something unfamiliar? |