



MGHfC Autism Care Plan

Would you like to fill this out online? Visit <https://redcap.partners.org/redcap/surveys/?s=e2wykW>

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone Number: _____

Expressive Communication:

1. How does the individual express their needs/desires? Check all that apply.

- Spoken Language
- Sign Language
- Pictures
- Pictures with text
- Typed words
- Handwritten words
- Electronic device
- Gesturing or pointing
- Gestures other than pointing
- Facial Expressions
- Intonation
- Other _____

2. How does the individual say yes/no? _____

3. How does the individual express pain? Check all that apply.

- Crying/Screaming
- Spoken Language
- Self Injury
- Aggression
- Pointing
- Other, please explain: _____

Receptive Communication:

1. How does the individual understand new information or instructions? Check all that apply.

- Spoken Language
- Sign Language
- Pictures
- Pictures with text
- Typed words
- Handwritten words
- Social Stories
- Electronic device: _____
- To Do/Finished Boards
- First/Then Boards
- Other, please explain: _____

2. How does the individual understand the passage of time? Check all that apply.

- Using a clock
- Using a timer
- Using schedule boards
- Counting aloud

- Other, please explain: _____

Social/Pragmatic:

1. What is the best way for doctors or nurses to greet this individual? Please Describe: _____

2. What is the best way for doctors or nurses to examine this individual? Check all that apply.
 - Allow the patient to examine any instruments him or herself first
 - Hide instruments until their use becomes necessary
 - Model parts of the exam on trusted adult or doctor/nurse
 - Communicate with the patient (using the favored communication method) before each step of the exam
 - List or count things that the doctor needs to do; i.e. 1-look at eyes, 2-look in ears, 3-listen to heart, etcAdditional information we should know: _____

3. Is there a part of the exam that would not be tolerable to this individual?
 - Stethoscope
 - Eyes
 - Ears
 - Throat
 - Belly Exam
 - Reflexes
 - Blood Pressure cuff
 - Other, please explain: _____
4. Are there particular words, phrases, or actions that may trigger anxiety in the individual?
 - Yes ○ NoIf Yes, please explain: _____

5. Which of the following may be helpful? Check all that apply.
 - Escort upon arriving at the hospital
 - Map of hospital layout
 - Low Lighting
 - Sunglasses
 - Noise-cancelling headphones
 - Weighted blanket
 - Access to music, puzzles, videos, etc.
 - Other, please explain: _____
6. Will the individual be comfortable wearing a hospital gown?
 - Yes ○ No
7. Will the individual tolerate wearing a hospital I.D. band on their wrist?
 - Yes ○ No
8. Please indicate any behaviors that are likely to require staff assistance. Check all that apply.
 - Physical motion (rocking, flapping, squeezing hands)
 - Vocalizations
 - Self-injurious behaviors
 - Other, please explain: _____
9. What INITIAL strategies are helpful when helping the individual self regulate?
 - Leave them alone/ignore
 - Attempt to engage

- Allow distance/space
- Other, please explain: _____

10. Does the individual sleep through the night?

- Yes
- No

If No, what strategies do you use to settle or redirect the individual? Please Explain: _____

11. Do you have any safety concerns for the individual's stay?

- Yes
- No

If Yes, please explain: _____

Sensory/Perceptual:

Is the individual sensitive to... (Check all that apply.)

1. Sound

- Loud volume
- Unexpected noises
- Other: _____

2. Visual stimuli

- Bright lights
- Specific colors
- Other: _____

3. Smell

- Allergy to fragrance
- Other: _____

4. Touch

- Increased sensitivity to texture
- Seeks pressure
- Avoids touch
- Avoids specific touch

Explain: _____

5. Taste/Feeding

- Food allergies: _____
- Eliminated diet (i.e. gluten/casein free): _____
- Food aversions: _____

If the diet is self-limited, what does the individual eat? Please explain: _____

Does the individual tolerate different foods on the same plate?

- Yes
- No

Other: What additional information should we know in planning the individual's admission to the hospital?

Mail completed form to: Sarabeth Broder-Fingert, M.D.
Department of Pediatrics, Massachusetts General Hospital for Children,
175 Cambridge St., CPZS-501c Boston, MA 02114

Questions? Contact Sarabeth Broder-Fingert, M.D. at myhospitacareplan@gmail.com
Copyright © 2011 Massachusetts General Hospital. All Rights Reserved.