THE CHILDREN'S HOSPITAL
AT SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

Autism Care Questionnaire (ACQ)

Patient name: _____ **Patient current age:** _____

Patient date of birth: __ __ / __ __ / __ __ __ __ (m m d d y y y y) **Date:** __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Name of person completing this form: _____

Relationship to the patient: _____

GUARDIANSHIP INFORMATION (only for patients age 18 years or older)

Does the patient have a guardian? □ Yes □ No □ Not Applicable

If yes: **Guardian name:** _____

Guardian contact information: _____

If the guardian has been appointed by the court, a copy of the guardianship should be submitted to the hospital or doctor.

We want to make sure that your visits to the hospital or doctor are a positive experience. Please fill out this form to help us learn about you/the patient so we can better meet your/the patient's needs.

COMMUNICATION

1. How does the patient like to communicate needs/wants? (check all that apply)

- □ Talking
- □ Sign language
- □ Typed words
- □ Handwritten words
- □ Tablet or communication device
- □ Pointing/gesturing
- □ Pictures or symbols
- □ Pictures with words
- □ Making sounds
- □ Facial expressions (smiling, frowning, etc.)
- □ Other: _____

2. What other ways will the patient tell us what he/she needs/wants? (check all that apply)

- □ Talking
- □ Sign language
- □ Typed words
- □ Handwritten words
- □ Tablet or communication device
- □ Pointing/gesturing
- □ Pictures or symbols
- □ Pictures with words
- □ Making sounds
- □ Facial expressions (smiling, frowning, etc.)
- □ Other: _____

3. How does the patient communicate "yes" or "no" when asked a question?

4. How does the patient learn new information or instructions? (check all that apply)

- □ Talking
- □ Sign language
- □ Typed words
- □ Handwritten words
- □ Tablet or communication device
- □ Stories
- □ Pictures or symbols
- □ Pictures with words
- □ To Do/Finished boards
- □ First/Then boards
- □ Other: _____

5. How does the patient know that time is passing? (check all that apply)

- □ Using a clock or watch
- □ Using a timer
- □ Using schedule boards
- □ Counting aloud
- □ Other: _____

6. **What is the best way for us to prepare the patient for tests (i.e. how long the wait will be for a test or how long the test will take)?**

7. **How will the patient tell us that he/she has to go to the bathroom?**

8. **How will the patient tell us that he/she is hungry or thirsty?**

9. **How will the patient let us know if he/she is in pain? (check all that apply)**

- ☐ Talking
- ☐ Sign language
- ☐ Typed words
- ☐ Handwritten words
- ☐ Tablet or communication device
- ☐ Pointing/gesturing
- ☐ Pictures or symbols
- ☐ Pictures with words
- ☐ Making sounds
- ☐ Crying
- ☐ Facial expressions (frowning, etc.)
- ☐ Hitting or hurting self
- ☐ Hitting or hurting others
- ☐ Other: _____

10. **Are there other ways the patient will let us know that he/she is in pain?** ☐ Yes ☐ No

If yes: What ways? _____

HOSPITAL VISIT and EXAMINATION

1. **How should we greet the patient?**

2. **What is the best way for us to examine the patient?**

- ☐ Communicate with the patient (using the favored communication method) before each step of 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, etc.)
- ☐ Do parts of the exam on someone else first
- ☐ Allow the patient to touch any instruments (i.e. stethoscope, blood pressure cuff) him or herself
- ☐ Hide instruments until their use becomes necessary
- ☐ Distract the patient from the examination
- ☐ Other: _____

3. **Is there a part of the exam that may especially bother the patient? (check all that apply)**

- ☐ Using a stethoscope to listen to lungs
- ☐ Checking blood pressure with the cuff
- ☐ Eye test
- ☐ Ear test
- ☐ Looking in mouth/throat
- ☐ Belly exam
- ☐ Testing reflexes
- ☐ Other: _____

4. **Will the patient wear a hospital gown?** ☐ Yes ☐ No

If no: What would the patient want to wear? _____

5. **Will the patient wear a hospital ID band on their wrist?** ☐ Yes ☐ No

If no: Please let us know before the patient comes to the hospital to discuss options since all patients must wear a hospital ID.

Patient name: _____

Patient date of birth: _____

COMFORT and SAFETY

1. **Is the patient sensitive to:**
   - ☐ Loud noises
   - ☐ Unexpected noises
   - ☐ Bright lights
   - ☐ Specific colors
   - ☐ Fragrances/smells
   - ☐ Textures
   - ☐ Touch
   - ☐ Specific types of touch
   - ☐ Other: _____

2. **How long does the patient usually sleep at night?** _____

3. **Will a family member or caregiver be staying with the patient?** ☐ Yes ☐ No
   If yes: What hours will the caregiver be at the hospital? _____

4. **Are there special ways to make mealtimes easier?** ☐ Yes ☐ No
   If yes: What ways? _____

5. **Is the patient on a special diet?** ☐ Yes ☐ No
   If yes: What type? _____

6. **Are there special times of the day that the patient eats snacks or meals?** ☐ Yes ☐ No
   If yes: What times? _____

7. **Does the patient prefer that different foods in a meal not touch, or to have separate plates for each type of food?** ☐ Yes ☐ No
   If yes: What does the patient like? _____

8. **Are there any words, phrases or actions that will upset the patient?** ☐ Yes ☐ No
   If yes: What are they? _____

9. **How will the patient let us know if he/she is upset/anxious? (check all that apply)**
   - ☐ Talking
   - ☐ Sign language
   - ☐ Typed words
   - ☐ Handwritten words
   - ☐ Tablet or communication device
   - ☐ Pointing/gesturing
   - ☐ Pictures or symbols
   - ☐ Pictures with words
   - ☐ Making sounds
   - ☐ Facial expressions (smiling, frowning, etc.)
   - ☐ Physical motions (rocking, flapping, squeezing hands)
   - ☐ Hitting or hurting self
   - ☐ Hitting or hurting others
   - ☐ Other: _____

10. **What comforts the patient when he/she gets upset or anxious? (check all that apply)**
    - ☐ Talk to him/her
    - ☐ Leave him/her alone
    - ☐ Give the him/her some space
    - ☐ Other: _____

11. **What may help decrease the patient's anxiety? (check all that apply)**
    - ☐ A map of the hospital
    - ☐ Low lighting
    - ☐ Sunglasses
    - ☐ Headphones to decrease noise
    - ☐ A heavy blanket
    - ☐ An escort that will help the patient around the hospital
    - ☐ Music
    - ☐ Videos
    - ☐ Puzzles/games
    - ☐ Other: _____

12. **Are there any other safety concerns we should know about?** ☐ Yes ☐ No
    If yes: What are the concerns? _____

13. **Is there anything else we should know about so we can make the patient's visit as positive as possible?**