



Child's name _____
Age _____

Date _____
Relationship to child _____

M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer no. Please circle yes or no for every question. Thank you very much.

If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?) Yes No

Have you ever wondered if your child might be deaf? Yes No

Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) Yes No

Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs) Yes No

Does your child make unusual finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?) Yes No

Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach) Yes No

Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road) Yes No

Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?) Yes No

Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck) Yes No

Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) Yes No

When you smile at your child, does he or she smile back at you? Yes No

Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?) Yes No

Does your child walk? Yes No

Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? Yes No

Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do) Yes No

If you turn your head to look at something, does your child look around to see what you are looking at? Yes No

Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?) Yes No

Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don't point, can your child understand "put the book in the chair" or "bring me the blanket"?) Yes No

If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) Yes No

Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee) Yes No



Lead Risk Questionnaire

Pb-110

Purpose: To identify children who need to be tested for lead exposure.

Instructions

- If Yes or Don't Know, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

Patient's Name: _____ DOB: _____ Medicaid #: _____ Date: _____
 Provider's Name: _____ Administered by: _____

Questions

1. Does your child live in or visit a home, day-care or other building built before 1978? Yes or Don't Know No
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?
3. Does your child eat or chew on non-food things like paint chips or dirt?
4. Does your child have a family member or friend who has or did have an elevated blood lead level?
5. Is your child a newly arrived refugee or foreign adoptee?
6. Does your child come in contact with an adult whose job or hobby involves lead exposure?

Examples

- House construction or repair
 - Battery manufacturing or repair
 - Burning lead-painted wood
 - Automotive repair shop or junk yard
 - Going to a firing range or reloading bullets
 - Chemical preparation
 - Valve and pipe fittings
 - Brass/copper foundry
 - Refinishing furniture
 - Making fishing weights
 - Radiator repair
 - Pottery making
 - Lead smelting
 - Welding
7. Does your family use products from other countries such as pottery, health remedies, spices, or food?

Examples

- Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alcoh, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda
- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.
- Foods canned or packaged outside the U.S.

Fax this form to 512-776-7699 or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program • Texas Department of State Health Services
 PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

Test Immediately

PEDS RESPONSE FORM

Provider _____

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

Please list any other concerns.