New Jersey Department of Health
NEW JERSEY AUTISM REGISTRY
PO Box 364, Trenton, NJ 08625-0364
Fax: 609-292-8235

AUTISM REGISTRATION

CHILD'S INFORMATION

Name of Child (as appears on birth certificate)

Last Name	Suffix	First Name ☐ None Given	Middle Name

Also Known As

Last Name	Suffix	First Name ☐ None Given	Middle Name

Child's Current Residence Address

Street Address	Unit Description	Unit	P.O. Box

City	State	Zip Code	County	Country

Hospital / Place of Birth

Medical Facility Name or Description of Location ☐ Unknown	City	State	Country

Primary Care Provider

Practice Name -OR- Provider Name *(Last Name, First Name)* ☐ Undecided ☐ Unknown	Telephone Number ( ) Extension

Birth Information

Date of Birth	Sex	Birthweight	Plurality	If Multiple, Birth Order:	Weeks of Pregnancy
	☐ Female ☐ Male ☐ Indeterminate	____ Grams -OR- ____ Lbs., ____ Ozs. -OR- ☐ Unknown	☐ Single ☐ Twin ☐ Other Multiple: ___ ☐ Unknown		☐ Preterm (<37 Wks.) ☐ Term (37-41 Wks.) ☐ Post term (≥42 Wks.) ☐ Unknown

Ethnicity Information

Hispanic/Latino ☐ Yes ☐ No ☐ Unknown

Primary Language Spoken in Home ☐ English ☐ Spanish ☐ Other, Specify: _____

Race *(Check ALL that apply)*

☐ White ☐ Black/African American
☐ Chinese ☐ American Indian/Native Alaskan
☐ Japanese ☐ Native Hawaiian
☐ Korean ☐ Filipino
☐ Vietnamese ☐ Guamanian or Chamorro
☐ Asian Indian ☐ Samoan

☐ Other Asian, Specify: _____
☐ Other Pacific Islander, Specify: _____
☐ Other, Specify: _____
☐ Not Classifiable / Unknown

Birth Mother's Residence at Time of Birth
(If mother was institutionalized at time of birth, enter residence address before she was institutionalized.)

☐ Unknown ☐ Same as child's current residence address

Street Address	Unit Description	Unit	P.O. Box

City	State	Zip Code	County	Country

CASE TRACKING INFORMATION

Medical Record Number	Birth Certificate/VIP Number

INSURANCE INFORMATION

Insurance Type ☐ None ☐ Private ☐ Medicaid ☐ Unknown

INFORMATION ON PERSON SUBMITTING REPORT

Submitted by ☐ Diagnostician(s) or their Staff/Facility ☐ Case Manager (SCHS/EI) ☐ Primary Care Provider ☐ Other Health Care Provider/Facility

Title ☐Dr. ☐Mr. ☐Ms.	Name (Last, First)

Practice/Facility Name	Telephone Number ( ) ☐ No Phone

Street Address	Unit Description	Unit	P.O. Box

City	State	Zip Code	Country (if not USA)

AUTISM REGISTRATION (Continued)

PARENT A INFORMATION

Parent A Vital Status ☐ Alive ☐ Dead ☐ Unknown | Sex ☐ Male ☐ Female | Biological ☐ Yes ☐ No ☐ Unknown

Parent A Name

Last Name	Suffix	First Name	Middle Name	Maiden Name

Parent A Mailing Address

☐ Same as child's current residence address

Street Address	Unit Description	Unit	P.O. Box

City	State	Zip Code	County	Country

Parent A Legal Guardian Status ☐ Yes ☐ No ☐ Unknown | Date of Birth | Telephone Number ( ) ☐ No Phone

PARENT B INFORMATION

Parent B Vital Status ☐ Alive ☐ Dead ☐ Unknown | Sex ☐ Male ☐ Female | Biological ☐ Yes ☐ No ☐ Unknown

Parent B Name

Last Name	Suffix	First Name	Middle Name

Parent B Mailing Address

☐ Same as child's current residence address

Street Address	Unit Description	Unit	P.O. Box

City	State	Zip Code	County	Country

Parent B Legal Guardian Status ☐ Yes ☐ No ☐ Unknown | Date of Birth | Telephone Number ( ) ☐ No Phone

GUARDIAN INFORMATION IS TO BE COMPLETED ONLY IF NEITHER PARENT IS THE LEGAL GUARDIAN!

GUARDIAN INFORMATION

Legal Guardian Status ☐ Yes ☐ No ☐ Unknown | Guardian Type ☐ Relative ☐ Individual (Non-Relative) ☐ Government Agency (DCP&P, etc.) ☐ Private Agency

Guardian Name

Last Name	Suffix	First Name	Middle Name

Contact Information

Telephone Number ( ) ☐ No Phone

Mailing Address

☐ Same as child's current residence address

Street Address	Unit Description	Unit	P.O. Box

City	State	Zip Code	County	Country

IF AGENCY IS THE LEGAL GUARDIAN, THEN COMPLETE GUARDIAN AGENCY INFORMATION

Guardian Agency Information

Agency Name	Division/Program

Street Address	Unit Description	Unit	P.O. Box

City	State	Zip Code	County	Country

Guardian Agency Contact Information

Contact Name *(Last Name, First Name)* | Telephone Number ( ) ☐ No Phone

AUTISM REGISTRATION (Continued)

REGISTRATION

Registering this Child for:
☐ First Registration ☐ Updated Registration ☐ Audit

☐ YES, Parent/Guardian Requests Non-Identifiable Autism Registration

DIAGNOSTICIAN INFORMATION

Name *(Last, First)*

Highest Degree
☐ MD/DO ☐ Doctorate ☐ Masters ☐ Unknown

Specialty
☐ Family Practice ☐ Pediatrics–General ☐ Pediatrics–Neurology ☐ Social Work
☐ Neurology ☐ Pediatrics-Developmental/ ☐ Pediatrics–Psychiatry ☐ Other *(specify)*: _____
☐ Neuropsychology Neurodevelopmental ☐ Psychology ☐ Unknown

Name of Practice/Facility where Diagnosis Made

AUTISM DIAGNOSIS INFORMATION

☐ Autism Spectrum Disorders (ASD)
IF PREVIOUSLY DIAGNOSED, SPECIFY TYPE *(Choose One):*
☐ Autistic Disorder
☐ Pervasive Developmental Disorder NOS
☐ Asperger's Disorder
☐ No Longer Meets Criteria
☐ NEVER Met Criteria

Date of Diagnosis *(Month/Day/Year)*

Is this the FIRST TIME this child has been diagnosed with an ASD? ☐ Yes ☐ No

If NO, then at what age was this child diagnosed with an ASD? _____ Years _____ Months

Age Symptoms First Noted by Anyone?
_____ Years _____ Months ☐ Unknown

Instruments/References Used *(check all that apply)*:
☐ ABC Autism Behavior Checklist
☐ ADI-R Autism Diagnostic Interview - Revised
☐ ADOS Autism Diagnostic Observation Schedules
☐ CARS Childhood Autism Rating Scale
☐ DSM-5 Diagnostic and Statistical Manual, 5th Ed.
☐ DSM-IV-TR Diagnostic and Statistical Manual, 4th Ed.-TR
☐ GARS-3 Giliam Autism Rating Scale
☐ Other *(specify)*: _____

If Diagnosed using the DSM-5, indicate the levels of support needed for:
Restricted, Repetitive Behavior Severity Levels:
☐ Level 3: Requiring VERY substantial support
☐ Level 2: Requiring substantial support
☐ Level 1: Requiring support
Social and Communication Severity Levels:
☐ Level 3: Requiring VERY substantial support
☐ Level 2: Requiring substantial support
☐ Level 1: Requiring support
☐ Unknown/Not Assessed

Additional Diagnoses *(Check all that apply)* NOTE: All Congenital Diagnoses should be listed below.
☐ ADHD/ADD ☐ Schizophrenia ☐ Tic Disorder/Tourette's ☐ Obesity
☐ Depression ☐ Anxiety, including OCD ☐ Seizure Disorder/Epilepsy ☐ Eczema
☐ Mood/Bipolar ☐ Oppositional Defiant Disorder ☐ Asthma ☐ Intellectual Disability

OTHER DIAGNOSIS INFORMATION

Other Diagnosis Descriptions *(Be Specific and include all congenital diagnoses):*

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SYMPTOMS/BEHAVIORS INFORMATION

Verbal Ability at the Time of Registration
☐ Nonverbal (no language at all)
☐ Limited verbal skills *(specify all that apply below, if known)*:
☐ Stereotyped and repetitive use of language (echolalia)
☐ Problems taking steps to start a conversation/lacking pragmatic language
☐ Uses mostly sign language/assistive devices to get needs met
☐ Difficulty understanding others when spoken to
☐ Verbal skills appropriate for developmental age
☐ Unknown

Intellectual Disability/Cognitive Impairment
☐ Not measured/assessed or unknown ☐ IQ is 71 to 85
☐ IQ score is 70 or below ☐ IQ is above 85

Symptoms/Behaviors at the Time of Registration
(Check all that apply):
☐ Aggressiveness towards others
☐ Constipation/gastro-intestinal issues
☐ Coordination issues/motor skills difficulties
☐ Excessive tantrums not due to developmental age
☐ Feeding disorder/difficulties
☐ Hyperlexia
☐ Self-injurious behavior
☐ Sensory integration issues
☐ Sleep disruptions/disturbances
☐ Wandering/elopement
☐ Unknown

MEDICATION INFORMATION

Medication(s) Used at the Time of Registration *(Check all that apply)*:
☐ Alpha Agonist (guanfacine, clonidine)
☐ Anticonvulsants (barbiturates, aldehyde, Depakote, Lamictal)
☐ Antidepressants-SSRI (Prozac, Zoloft, Lexapro)
☐ Antidepressants-Trycyclic, SSNRI, etc. (Cymbalta, Wellbutrin, Elavil)
☐ Anxiolytics (Buspar, Ativan)
☐ CAMS (Complementary/Alternative) (massage therapy, yoga, acupuncture)
☐ Neuroleptics (Risperdal, Abilify, Seroquel)
☐ Non-stimulants (Strattera)
☐ Nutritional Supplements (vitamins, minerals, herbs)
☐ Sleep Aid (Ambien, Lunesta, Rozerem, or melatonin)
☐ Stimulants (Ritalin, Adderall)
☐ Other *(specify)*: _____
☐ Unknown

Does the child have a sibling(s) diagnosed with an ASD? ☐ Yes – How many? _____ ☐ No ☐ Unknown