Early Identification of Children with Special Health Care Needs (CSHCN) Practice Initiative
Pre-Assessment Tool

Date: __________________________ Health Care System: __________________________________________

Medical Home/Primary Care Practice Site: __________________________________________________

Address: __________________________ County: ________________________

Medical Provider/Contact Person: __________________________ Title: _____________________________

Phone: ___________________________ Email: ________________________________________________

General Developmental Screening – Practice Management
1. In your practice do you perform general developmental screening using a standardized validated tool?  
   ☐ Yes ☐ Planning to do so as part of this Initiative

   a) If Yes: Indicate the tool(s) you are currently using and at what ages.

      ☐ ASQ Age(s): ________________
      ☐ ASQ-SE Age(s): ________________
      ☐ PEDS Age(s): ________________
      ☐ Other Age(s): ________________

   b) If Yes: How frequently do you perform general developmental screening, as recommended by
      the American Academy of Pediatrics at:
    • 9 month well-child exams
      ☐ Very Frequently (>75%) ☐ Moderately (25-75%) ☐ Not Frequently (<25%) ☐ Not at all
    • 18 month well-child exams
      ☐ Very Frequently (>75%) ☐ Moderately (25-75%) ☐ Not Frequently (<25%) ☐ Not at all
    • 24 or 30 month well-child exams
      ☐ Very Frequently (>75%) ☐ Moderately (25-75%) ☐ Not Frequently (<25%) ☐ Not at all

   c) If Yes: How frequently do you perform general developmental screening using a standardized,
      validated tool for any child under the age of 5 when developmental surveillance indicates
      increased risk of developmental delay?
      ☐ Very Frequently (>75%) ☐ Moderately (25-75%) ☐ Not Frequently (<25%) ☐ Not at all

ASD Screening – Practice Management
2. In your practice do you perform Autism Spectrum Disorder (ASD) specific screening using a
   standardized, validated ASD screening tool?  ☐ Yes ☐ Planning to do so as part of this Initiative

   a) If Yes: Indicate the tool(s) you are currently using and at what ages.

      ☐ CHAT Age(s): ________________
      ☐ M-CHAT Age(s): ________________
      ☐ CAST Age(s): ________________
      ☐ PDDST-II PCS Age(s): ________________
      ☐ STAT Age(s): ________________
      ☐ Other Age(s): ________________

(Continue on next page)
b) If Yes: How frequently do you perform ASD-specific screening as recommended by the AAP?
   - 18 month well-child exams
     - Very Frequently (>75%)
     - Moderately (25-75%)
     - Not Frequently (<25%)
     - Not at all
   - 24 month well-child exams?
     - Very Frequently (>75%)
     - Moderately (25-75%)
     - Not Frequently (<25%)
     - Not at all

c) If Yes: How frequently do you perform ASD-specific screening for any child under the age of 5 when developmental surveillance indicates increased risk of ASD?
   - Very Frequently (>75%)
   - Moderately (25-75%)
   - Not Frequently (<25%)
   - Not at all

Newborn Hearing – Practice Management
3. How frequently are the results of the hospital newborn hearing screen available to you at the time of the first newborn visit?
   - Very Frequently (>75%)
   - Moderately (25-75%)
   - Not Frequently (<25%)
   - Not at all

4. In the past six months, approximately how many infants have you seen in your practice who failed their newborn hearing screen?
   - None
   - 1-5
   - More than 5
   - Don’t know

Awareness
5. How familiar are you with community resources available for families of children, who have had concerning screening results?
   - Very Familiar
   - Moderately Familiar
   - Not Very Familiar

6. How familiar are you with the following programs:
   - Birth-3 (Wisconsin’s Part C early intervention program)
     - Very Familiar
     - Moderately Familiar
     - Not Very Familiar
   - Regional Centers for Children and Youth with Special Health Care Needs
     - Very Familiar
     - Moderately Familiar
     - Not Very Familiar
   - Wisconsin Sound Beginnings (Early Hearing Detection and Intervention program)
     - Very Familiar
     - Moderately Familiar
     - Not Very Familiar

Referrals to Birth-3, Early Childhood, and Regional Centers for CYSHCN
7. In the past six months, approximately how many referrals did you make to:
   - Part C early intervention (Birth-3 Program) for children under 1 year of age?
   - Part C early intervention (Birth-3 Program) for children birth-3 years of age?
   - Section 619/ early childhood special education for children 3-5 years of age?

8. In the past 6 months, how many of the above referrals were for children diagnosed as deaf or hard of hearing?
   - None
   - 1-5 referrals
   - More than 5 referrals
   - Don’t know

9. In the past 6 months, approximately how many referrals did you make to your Regional Center for CYSHCN?
Technical Assistance

10. The expectations of your participation in the Early Identification of CSHCN are delineated on the Participant Agreement Form. Based on these expectations, what technical assistance would you like to receive to support your meeting those expectations from the Technical Assistant Consultant, Regional Center for CYSHCN, and / or local Birth to Three?

☐ Learn more about use of the ASQ 3 in a practice setting
☐ Learn more about the use of the ASQ-SE in a practice setting
☐ Learn more about ASD specific screening in a practice setting
☐ Learn more about making referrals to local Birth to Three
☐ Learn more about making referrals to my local CYSHCN Regional Center
☐ Learn more about community resources available to our practice
☐ Learn more about community resources available to families
☐ Other: ________________________________

Return completed form along with your Practice Agreement form

By Mail: Christine Breunig, Early ID Technical Assistance Consultant
Regional Center for CYSHCN
325 North Commercial Street - Suite 400
Neenah, WI  54956

By Fax: (920) 969-7975

Or

By Email: Christine Breunig at cbreunig@chw.org

For technical assistance and other questions call (920) 969-5330 or 1-877-568-5205