Connecting to Care

Far Northern Regional Center

Psychiatric TeleHealth Consultation

Referral Packet

3330 Churn Creek Road, Suite D5, Redding, CA 96002
Phone: (530) 722-1156   Fax: (530) 722-1154

What is TeleHealth?

TeleHealth uses advanced camera and video technology to connect you, your primary medical care provider, and Far Northern Regional Center to a specialist from another location. The specialist can assist your primary care provider and Far Northern Regional Center in determining your diagnostic condition and intervention needs. TeleHealth developed because there is a shortage of local specialists, especially in rural areas.

TelePsychiatry brings the patient, family, and support staff together in a *virtual* clinic. The psychiatrists who provide services for Far Northern Regional Center work as consultants and do the same assessment as would be done in person or in a regular office visit. The psychiatrist's consultation notes and recommendations are sent to your primary care provider. Your primary care provider, who knows you best, makes the final determination on your specific treatments. You are welcome to bring people with you to your appointment if you think they will assist the psychiatrist in better understanding your needs.

Is there someone who can answer questions about the Tele-Psychiatry session?

A facilitator at Connecting to Care is present during TeleHealth consultations and will guide you and your care team through the process.

How long does it take?

Your first visit may take up to an hour. After that most visits take about 30 minutes.

What will happen during the TelePsychiatry consultation?

A special camera and video equipment will allow the specialist to see and hear you so you can talk with another. The specialist may ask you questions and suggest treatment recommendations. This information will then be communicated to your primary medical care provider for follow-up with you and your care team.

What are the benefits of TeleHealth?

You won't have to travel to see your specialist. Your specialist can see and talk with you and others involved in your care at the same consultation. Your primary care provider can send your medical information to your specialist for a second opinion. Your service coordinator and primary care provider are involved, providing greater continuity of care.

CONNECTING TO CARE
DOCUMENT LIST FOR TELEHEALTH

Client Name: ______________________ DOB: ______________

Date: ______________________

1. Far Northern Regional Center TeleHealth Consultation Referral Form ________
2. SANDIS Consumer Profile ________
3. FNRC Annual Review, IPP/Addendums ________
4. Authorization for Use or Release of Information ________
5. Authorization and Consent to Participate in TeleHealth ________
6. Liability Waiver/Release of All Claims ________
7. Physician's Order for TeleHealth ________
8. Aberrant Behavior Check-List ________
9. Behavior Problems Inventory ________
10. Psychiatric evaluations and medication list for psychotropic medications ________
11. All psychological evaluations and therapy notes ________
12. All medical evaluations and medication log from all medical care providers ________
13. All lab, exam, test results; EEG, images, genetic testing, etc. ________
14. School psycho-educational evaluations and IEPs ________

1-9 REQUIRED

10-14 Please supply all available documentation

FAR NORTHERN REGIONAL CENTER

TeleHealth Consultation Referral Form

Client Name: ______________________________Date of Referral: _______________

DOB: __________________UCI #: __________________

Service Coordinator: _______________________________

FNRC Diagnosis: _________________________________

Other Diagnoses: ____

____

Primary Contact:

Name: _______________________ Relationship: ____________________________

Name of Facility if Applicable: ____

Mailing Address (Including City, State, Zip): ___________________________________

____

Email Address: ____

Phone: (Home) ______________________ (Work) ______________________

(Cell) _______________________ (Fax) _______________________

Name of Current Primary Care Provider: _____________________________________

Title (Circle One): MD DO FNP PA

Name of Clinic/Medical Group: _______________________ ______________________

Address (Including City, State, Zip): ____

____

Phone: ____________________________ Fax: _______________________________

Clients Name: ________________________________DOB: ______________________

Specialty Physician: ____

Address (Including City, State, Zip): ____

____

Phone: ______________________________ Fax: ______________________________

Please list all specialty physicians on reverse side if applicable.

Behavioral Concerns (including frequency, duration, and severity): __________________

____

____

Other (sleep habits, hallucinations, etc.): _______________________________________

____

____

Suspected Precipitating Factors (Holidays, Home Visits, etc.): ______________________

____

____

Day Program\School\Work Site: ____

Please indicate how many days per week and primary activities:______________________

____

____

FOR OFFICE USE ONLY
Approved by Case Management Supervisor: ______________________________________

Date Approved: Date Received:

Please list all current medications: (You may attach MARs or existing list).

Clients Name: ________________________________DOB: _______________________

Current Medication	Dosage	Reason Given	Prescribing Physician	Please Note any Side Effects

CONNECTING TO CARE

Authorization for Use or Release of Information for TeleHealth Consultations

Client's Name: ____ **DOB:** ______________________

Primary Care Physician: ____

TeleHealth Specialty Facility: **Roxy Szeftel, MD and Associates**

I understand that my primary care physician listed above wants me to consult with one or more specialists at the specialty facility listed above about how best to treat me. I have voluntarily agreed to talk with the specialist(s) via a remote video connection. Connecting to Care (CtoC) will arrange the appointment with the specialist(s) and provide the remote connection for the TeleHealth visit. CtoC is providing these TeleHealth services as a vendor for the Far Northern Regional Center (FNRC).

I am hereby authorizing my primary care physician, primary caregiver, parent or guardian as well as FNRC personnel, to release to CtoC staff and contractors any medical information about me, including my medical history, diagnostic test results and encounter notes, needed by the specialist to provide meaningful input on a treatment plan for me.

To the extent necessary to conduct the TeleHealth visit, I am hereby authorizing the CtoC staff and/or contractors to view and hear the conversation between the specialist and me. I understand that the conversation will not be recorded.

I am also hereby authorizing the TeleHealth specialty facility listed above to release the report that the specialist(s) prepare to CtoC and I am authorizing CtoC to distribute that report to my primary care physician, primary caregiver, parent or guardian as well as to authorized personnel at FNRC.

CtoC may use the medical records and consultation report released under this authorization to arrange, conduct and bill for my TeleHealth consultation and for health care operation purposes such as quality assurance. In addition, CtoC may release the records and the report whenever it is required to do so under federal, state or local laws.

I understand that I may revoke this authorization at any time by notifying Connecting to Care in writing, but if I do, it will not have any affect on any actions that my physician, FNRC, the TeleHealth specialist or CtoC have taken before they received the revocation. The revocation should be addressed to Connecting to Care, 3330 Churn Creek Road, Suite D5, Redding, CA 96002.

Signature: ____ ______________________

Client (or client's legal representative) Date

Date: ______________________ Time: __________________ A.M. ☐ P.M. ☐

If signed by other than client, indicate relationship: ____

Witness: ____ Date: ___________________________

CONNECTING TO CARE

Authorization and Consent to Participate in TeleHealth Consultation

CLIENT NAME: ______________________________ DOB: ______________________

1. **PURPOSE**. The purpose of this form is to obtain your consent to participate in a TeleHealth consultation in connection with the following procedure(s): Psychiatric Services

2. **NATURE OF TELEHEALTH CONSULTATION**. During the TeleHealth consultation:

   a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.

   b. Non-medical technical personnel may be present in the TeleHealth studio to aid in video transmission.

   c. Video, audio, and/or photo recordings may be taken of the procedure(s).

3. **MEDICAL INFORMATION AND RECORDS**. All existing laws regarding your access to medical information and copies of your medical records apply to this TeleHealth consultation. Additionally, dissemination of any client-identifiable images or information from this TeleHealth interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY**. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with TeleHealth consultation, and all existing confidentiality protections under federal and California law apply to information disclosed during this TeleHealth consultation.

5. **RIGHTS**. You may withhold or withdraw consent to the TeleHealth consultation at any time without affecting the right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES**. This Agreement shall be governed by the laws of the State of California except for the choice of law rules used in that jurisdiction. Any dispute in any manner or degree relating to or arising from this Agreement shall be determined exclusively in the Courts of the State of California.

7. **RISKS, CONSEQUENCES AND BENEFITS**. I have been advised that TeleHealth utilizes the electronic transmission of data and that technical issues may affect the quality and integrity of the data transmitted via TeleHealth. The loss of data quality and integrity may adversely affect the treatment I receive via TeleHealth. I further understand that there may be limitations on the services available to me due to the lack of physical presence between the participants of a TeleHealth consultation and such limitations may adversely effect the treatment I receive via TeleHealth. By participating in TeleHealth consultations, I also understand that I will be receiving services which I might otherwise have to travel significant distances in order to obtain. My health care practitioner has discussed with me the information provided above and provided specific information relating to the risks, consequences and benefits of the TeleHealth services I receive as applied to my individual circumstances. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above and have given my verbal consent to participate in TeleHealth consultation.

Signature: ______________________________ ______________________

Client (or client's legal representative) Date

I refuse to participate in a TeleHealth consultation for the procedure(s) described above.

Signature: ____

Client (or client's legal representative)

Date: ____________________ Time: ________________ A.M. ☐ P.M. ☐

If signed by other than client, indicate relationship: ______________________________________

Witness: ______________________________________ Date: ________________________

CONNECTING TO CARE

Liability Waiver - Release of All Claims

(This form must be signed to participate)

CLIENT NAME: ____DOB:_____________________________

1. As lawful consideration for being permitted to participate in the Connecting to Care TeleHealth Program, I agree that I will not make a claim against, sue, attach the property of or prosecute Connecting to Care and its agents, affiliates and employees for damages for death, personal injury or property damage which I may sustain as a result of my participation in these TeleHealth services. This release is intended to discharge in advance Connecting to Care its agents, affiliates and employees from and against any and all liability, including for negligent actions, arising out of or connected in any way with my participation in the TeleHealth program, except for liability that may arise out of the willful or wanton misconduct of Connecting to Care and its agents, affiliates and employees.

2. I further understand that Connecting to Care is not providing any clinical or medical services and that TeleHealth involves the electronic transmission of data that is susceptible to technical difficulties and errors that may impact the quality and integrity of data transmitted via the TeleHealth services and such technical difficulties and data integrity errors may, directly or indirectly, result in serious personal injuries (including death) and/or property damage, as a consequence thereof. Knowing the risks of participation, nevertheless, I hereby agree to assume those risks and to release and hold harmless Connecting to Care and its agents, affiliates and employees who (through negligence or carelessness), might otherwise be liable to me (or my heirs or assigns) for damages.

3. I have carefully read this agreement and fully understand its contents. I am aware that this is a release of liability and a contract between myself and Connecting to Care and its agents, affiliates and employees, and I have signed it of my own free will.

I attest that I am eighteen (18) years old or older; or I am the duly authorized legal representative of the participant in the Connecting to Care TeleHealth Program.

Signature:____ ______________________

Client (or client's legal representative) Date

Date:______________________ Time:__________________ A.M. ☐ P.M. ☐

If signed by other than client, indicate relationship:____

Witness:____ Date:_________________________

PHYSICIAN ORDER FOR TELEHEALTH

As the Primary Care Provider for **Patient: ______________________ DOB: __________, I,**
__________________________,**(MD/FNP/PA)** agree to collaborate with TelePsychiatrist, **Dr. Heidi Sulman-Smith*,*** with Connecting to Care TeleHealth Services.

Diagnosis(es):

____

____

I understand that this is a consultative model only and I will be responsible for prescribing medications and/or other recommendations that the psychiatrist may make during these consultations. ***(The psychiatrist is available by phone should there be any questions regarding her recommendations.)***

______________________________ ____________________
Physician's Signature Date

Please sign and return this document to:
Connecting to Care
Attn: Heidi Johnson, Telehealth Coordinator
3330 Churn Creek Road, Suite D5
Redding, CA 96002
Ph: (530) 722-1156 Fax: (530) 722-1154
heidi@connectingtocare.org

ABBERRANT BEHAVIOR CHECKLIST

Clients Name: ________________________________

Rater's Name: ___________________________________

Clients Gender (circle): Male Female

Relationship to Client (check):
- ☐ Parent
- ☐ Teacher
- ☐ Trainer/Supervisor
- ☐ Other (please specify) __________________________

Date of Birth: ____/____/____
Month Day Year

Today's Date: ____/____/____
Month Day Year

Where was the Client Observed?
- ☐ Home
- ☐ School
- ☐ Residential Unit
- ☐ Other (please specify) __________________________

If in School, Type of Class (check one):
- ☐ Developmentally Handicapped
- ☐ Multi-handicapped
- ☐ Sever Behavior Handicap
- ☐ Other ______________________

Ethnic Group (check):
- ☐ Caucasian
- ☐ Hispanic
- ☐ African-American
- ☐ Other (please specify): ______________________________________

CLIENT'S MEDICAL STATUS (Please circle)

a. Deafness?	No	Yes	? (Don't Know)
b. Blindness?	No	Yes	?
c. Epilepsy?	No	Yes	?
d. Cerebral Palsy?	No	Yes	?

e. Other ____

CURRENT MEDICATIONS (Please list any medication and dosage schedule)

1. ____
2. ____
3. ____
4. ____
5. ____

INSTRUCTIONS

The ABC-Community rating scale is designed to be used with clients living in the community. Please note that the term *client* is used throughout to refer to the person being rated. This may be a child of school age, an adolescent, or an adult.

Please rate this client's behavior for the last four weeks. For each item, decide whether the behavior is a problem and circle the appropriate number:

0 = not at all a problem
1 = the behavior is a problem but slight in degree
2 = the problem is moderately serious
3 = the problem is severe in degree

When judging this client's behavior, please keep the following point in mind:

(a) Take relative *frequency* into account for each behavior specified. For example, if the client averages more temper outbursts than most other clients you know or most others in his/her class, it is probably moderately serious (2) or severe (3) even if these occur only once or twice a week. Other behaviors, such a noncompliance, would probably have to occur more frequently to merit an extreme rating.

(b) If you have access to this information, consider the experiences of other care providers with this client. If the client has problems with others but not with you, try to take the whole picture into account.

(c) Try to consider whether a given behavior interferes with his/her *development*, *functioning*, or *relationships*.

Do not spend too much time each item – your first reaction is usually the right one.

1.	Excessively active at home, school, work, or elsewhere.	0	1	2	3
2.	Injures self on purpose	0	1	2	3
3.	Listless, sluggish, inactive	0	1	2	3
4.	Aggressive to other children or adults (verbally or physically)	0	1	2	3
5.	Seeks isolation from others	0	1	2	3
6.	Meaningless, recurring body movements	0	1	2	3
7.	Boisterous (inappropriately noisy and rough)	0	1	2	3
8.	Screams inappropriately	0	1	2	3
9.	Talks excessively	0	1	2	3
10.	Temper tantrums/outbursts	0	1	2	3
11.	Stereotyped behavior; abnormal, repetitive movements	0	1	2	3
12.	Preoccupied; stares into space	0	1	2	3
13.	Impulsive (acts without thinking)	0	1	2	3
14.	Irritable and whiny	0	1	2	3
15.	Restless, unable to sit still	0	1	2	3
16.	Withdrawn; prefers solitary activities	0	1	2	3
17.	Odd, bizarre in behavior	0	1	2	3
18.	Disobedient; difficult to control	0	1	2	3
19.	Yells at inappropriate times	0	1	2	3
20.	Fixed facial expressions; lacks emotional responsiveness	0	1	2	3
21.	Disturbs others	0	1	2	3
22.	Repetitive speech	0	1	2	3
23.	Does nothing but sit and watch others	0	1	2	3
24.	Uncooperative	0	1	2	3
25.	Depressed mood	0	1	2	3
26.	Resists any form of physical activity	0	1	2	3
27.	Moves or rolls head back and forth repetitively	0	1	2	3

28. Does not pay attention to instructions	0	1	2	3
29. Demands must be met immediately	0	1	2	3
30. Isolates himself/herself from other children and adults	0	1	2	3
31. Disrupts group activities	0	1	2	3
32. Sits or stands in one position for a long time	0	1	2	3
33. Talks to self loudly	0	1	2	3
34. Cries over minor annoyances and hurts	0	1	2	3
35. Repetitive hand, body, or head movements	0	1	2	3
36. Mood changes quickly	0	1	2	3
37. Unresponsive to structured activities (does not react)	0	1	2	3
38. Does not stay in seat (e.g. during lesson or training periods, meals, etc.	0	1	2	3
39. Will not sit still for any length of time	0	1	2	3
40. Is difficult to reach, contact, or get through to	0	1	2	3
41. Cries and screams inappropriately	0	1	2	3
42. Prefers to be alone	0	1	2	3
43. Does not try to communicate by words or gestures	0	1	2	3
44. Easily distractible	0	1	2	3
45. Waves or shakes the extremities repeatedly	0	1	2	3
46. Repeats a work or phrase over and over	0	1	2	3
47. Stamps feet or bangs objects or slams doors	0	1	2	3
48. Constantly runs or jumps around the room	0	1	2	3
49. Rocks body back and forth repeatedly	0	1	2	3
50. Deliberately hurts himself/herself	0	1	2	3
51. Pay no attention when spoken to	0	1	2	3
52. Does physical violence to self	0	1	2	3
53. Inactive, never moves spontaneously	0	1	2	3
54. Tends to be excessively active	0	1	2	3
55. Responds negatively to affection	0	1	2	3
56. Deliberately ignores directions	0	1	2	3
57. Has temper outbursts or tantrums when he/she does not get own way	0	1	2	3
58. Shows few social reactions to others	0	1	2	3

BPI

THE BEHAVIOUR PROBLEMS INVENTORY
(BIP–1)

Johannes Rojahn Ph.D.

Name:	DOB:
ID:	
Date:	

(To assure confidentiality, keep this sheet separate from the rest of the instrument)

THE BEHAVIOR PROBLEMS INVENTORY

The Client

ID:___________ Age_____years____months Gender: ☐ male ☐ female

Ethnicity/Race: ☐ Euro-American ☐ African-American ☐ Asian/Pacific Islanders

☐ American Indian/Eskimo/Aleutian ☐ Hispanic-American White ☐ Hispanic-American Black

☐ Mixed ethnic background ☐ other/do not want to answer

Intelligence: ☐ superior (IQ>130) ☐ average (IQ 71-130)

☐ mild MR (IQ 56-70) ☐ moderate MR (IQ 41-55)

☐ severe MR (26-40) ☐ profound MR (<26)

☐ unknown

IQ – Test used:

☐ Stanford Binet ☐ WISC

☐ Slosson ☐ WAIS

☐ Leiter ☐ Unknown

☐ other (please specify):

The Respondent

Relationship to the client: ☐ biological parent ☐ guardian or foster parent

☐ non-parental relative ☐ teacher day program staff ☐ psychologist

☐ case manager ☐ behavior specialist ☐ other

Time you typically spent with the client per day: ____________________

How long have you known the client: ____________________

BPI Results Summary

Subscales	Frequency scores	Severity scores
SIB		
Stereotyped Behavior		
Aggressive/Destructive Behavior		

Instructions

On the following pages you will find generic definitions followed by specific descriptions of three types of behavior problems: self-injurious behaviors (items 1-15), stereotyped behaviors (items 16-40), and aggressive/destructive behaviors (items 41-52).

Please indicate which behaviors you have observed in this individual ***during the past two months*** by circling the number in the appropriate boxes to indicate (a) how often the described behavior typically occurs (frequency) and (b) how much of a problem the behavior represents (severity).

If the behavior has never been observed during the last two months, check "never" (i.e., number "0").

Scoring

Below are examples of three items scored for the behavior of a person named Jane:

1. Jane has never been seen biting herself (check "*never*" or "0" for item 1).
2. However, Jane slaps and punches her face. When unobserved, she does it almost constantly (check *"hourly*" or "4" for the frequency scale of item 2). This behavior potentially causes serious harm and Jane had thick calluses on her forehead (check "*severe*" or "3" on the severity scale).
3. Jane is also known to slap her thighs; this happens less frequently, every five to ten days or so (check "*weekly*" or "2" on the frequency scale of item 3). Nevertheless this behavior has been a big concern because it has cause serious bruises (check "*severe*" or "3" on the severity scale of item 3).
4. To obtain the subscale scores for these three items, sum up the numerical values of the checked boxes, separately for the frequency and the severity scales.

		Frequency					Severity		
		Never	Monthly	Weekly	Daily	Hourly	Slight	Moderate	Severe
1	Self-biting (so hard that a tooth print can be seen for some time; bloodshot or breaking of skin may occur)	**X**	1	2	3	4	1	2	3
2	Hitting head with hand or other body part (e.g., face slapping, knee against forehead) or with/against objects (e.g. slamming against a wall, knocking head with a toy)	0	1	2	3	**X**	1	2	**X**
3	Hitting body (except for the head) with own hand or with any other body part (e.g., kicking self, slapping arms or thighs), or with/against objects (e.g., hitting legs with a stick, boxing the wall)	0	1	**X**	3	4	1	2	**X**
		Frequency Total				6	Severity Total		6

SELF-INJURIOUS BEHAVIOR

Generic definition: Self-injurious behavior (SIB) causes damage to the person's own body; i.e., damage has either already occurred, or it must be expected if the behavior remained untreated. SIBs occur repeatedly in the same way over and over again, and they are characteristic for that person.

		Frequency					Severity		
		Never	Monthly	Weekly	Daily	Hourly	Slight	Moderate	Severe
1	Self-biting (so hard that a tooth print can be seen for some time, bloodshot or braking of skin may occur)	0	1	2	3	4	1	2	3
2	Hitting head with hand or other body part (e.g., face slapping, knee against forehead) or with /against objects (e.g., slamming against a wall, knocking head with a toy)	0	1	2	3	4	1	2	3
3	Hitting body (except for the head) with own hand or with any other body part (e.g., kicking self, slapping arms or thighs), or with/against objects (e.g. hitting legs with a stick, boxing the wall)	0	1	2	3	4	1	2	3
4	Self-scratching (so hard that reddening of the skin becomes visible; breaking of the skin may also occur)	0	1	2	3	4	1	2	3
5	Vomiting and rumination (deliberate regurgitation of swallowed food with rumination)	0	1	2	3	4	1	2	3
6	Self-pinching (so hard that reddening of the skin becomes visible; breaking of the skin may occur)	0	1	2	3	4	1	2	3
7	Pica: Mouthing or swallowing of objects which should not be mouthed or swallowed for health or hygiene reasons (non-food items such as feces, grass, paper, garbage, hair)	0	1	2	3	4	1	2	3
8	Inserting objects in body openings (in nose, ears, or anus, etc)	0	1	2	3	4	1	2	3
9	Pulling finger or toe nails	0	1	2	3	4	1	2	3
10	Inserting fingers in body openings (e.g., eye poking, finger in anus)	0	1	2	3	4	1	2	3
11	Air swallowing resulting in extended abdomen	0	1	2	3	4	1	2	3
12	Hair pulling (tearing out patches of hair)	0	1	2	3	4	1	2	3
13	Extreme drinking (e.g., more than 3 liters per day)	0	1	2	3	4	1	2	3
14	Teeth grinding (evidence of ground teeth)	0	1	2	3	4	1	2	3
15	Other…………………………………..	0	1	2	3	4	1	2	3
			Frequency Total				Severity Total		

STEREOTYPED BEHAVIOR

Generic definition: Stereotyped behaviors look unusual, strange or inappropriate to the average person. They are voluntary acts that occur repeatedly in the same way over and over again, and they are characteristic for that person. However, they do NOT cause physical damage.

		Never	Monthly	Weekly	Daily	Hourly	Slight	Moderate	Severe
16	Rocking back and forth	0	1	2	3	4	1	2	3
17	Sniffing objects	0	1	2	3	4	1	2	3
18	Spinning own body	0	1	2	3	4	1	2	3
19	Waving or shaking arms	0	1	2	3	4	1	2	3
20	Rolling head	0	1	2	3	4	1	2	3
21	Whirling, turning around on spot	0	1	2	3	4	1	2	3
22	Engaging in repetitive body movements	0	1	2	3	4	1	2	3
23	Pacing	0	1	2	3	4	1	2	3
24	Twirling Things	0	1	2	3	4	1	2	3

25	Having repetitive hand movements	0	1	2	3	4	1	2	3
26	Yelling and screaming	0	1	2	3	4	1	2	3
27	Sniffing own body	0	1	2	3	4	1	2	3
28	Bouncing around	0	1	2	3	4	1	2	3
29	Spinning objects	0	1	2	3	4	1	2	3
30	Having bursts of running around	0	1	2	3	4	1	2	3
31	Engaging in complex hand and finger movements	0	1	2	3	4	1	2	3
32	Manipulating objects repeatedly	0	1	2	3	4	1	2	3
33	Exhibiting sustained finger movements	0	1	2	3	4	1	2	3
34	Rubbing self	0	1	2	3	4	1	2	3
35	Gazing at hands or objects	0	1	2	3	4	1	2	3
36	Maintaining bizarre body postures	0	1	2	3	4	1	2	3
37	Clapping hands	0	1	2	3	4	1	2	3
38	Grimacing	0	1	2	3	4	1	2	3
39	Waving hands	0	1	2	3	4	1	2	3
40	Other……………………………………..	0	1	2	3	4	1	2	3
			Frequency Total				Severity Total		

AGGRESSIVE/DESTRUCTIVE BEHAVIOR

Generic definition: Aggressive or destructive behaviors are offensive actions or deliberate overt attacks directed towards other individuals or objects. They occur repeatedly in the same way over and over again, and they are characteristic for that person.

		Frequency					Severity		
		Never	Monthly	Weekly	Daily	Hourly	Slight	Moderate	Severe
41	Hitting others	0	1	2	3	4	1	2	3
42	Kicking others	0	1	2	3	4	1	2	3
43	Pushing others	0	1	2	3	4	1	2	3
44	Biting Others	0	1	2	3	4	1	2	3
45	Grabbing and pulling others	0	1	2	3	4	1	2	3
46	Scratching others	0	1	2	3	4	1	2	3
47	Pinching others	0	1	2	3	4	1	2	3
48	Spitting on others	0	1	2	3	4	1	2	3
49	Being verbally abusive with others	0	1	2	3	4	1	2	3
50	Destroying things (e.g., rips clothes, throws chairs, smashes tables)	0	1	2	3	4	1	2	3
51	Being mean or cruel (e.g., grabbing toys or food from others, bullying others)	0	1	2	3	4	1	2	3
52	Others………………………………………	0	1	2	3	4	1	2	3
			Frequency Total				Severity Total		