Autism Best Practice - Clinician Support Checklist

Visit Date (MM/YYYY) _____

Visit Type (circle one) New Follow-up visit # _____ since diagnosis Well Visit Age _____

Physician/Practitioner - First Name Initial _____ Last Name Initial _____

Instructions: This form is a decision support tool to help you develop habits for applying autism best practices for patients in your care. The questions are to get you thinking about how you will screen for the common conditions and issues and how you will ensure you are having important discussions and documenting those discussions in your treatment plan. *As part of continuous practice improvement, the goal is to work to improve your practice. There is no judgement, only opportunity for improvement. There are tools available like: standardized review of systems that parents/patients may complete prior to their visit, smart/auto-text phrases to help with documentation and other supports to guide your consistent practice implementation.*

You can complete this form on the day you see a person for a visit, or you can review your charts for a given time frame and see how you are doing. This form will guide you in what is best practice, show you where there may be gaps and where you may need tools to help with being more consistent in delivering best practice.

Section 1: These questions apply to every visit an autistic person has in your office.
Section 2: These questions apply to patients on medications.
Section 3: These questions apply to well/preventative visits, in addition to section 1.

Section 1: EVERY VISIT, EVERY TIME

1. Did you screen the child for **sleep concerns** (i.e., delayed onset, night wakings, snoring) during the visit?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No
2. Did you screen the child for **seizures concerns** (e.g., staring spells) during the visit?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No
3. Did you screen the child for **constipation** (i.e., painful, hard, infrequent stooling, stool accidents, stool holding) during the visit?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No
4. Did you screen the child for **nutritional concerns** during the visit?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No
5. Did you screen for **safety concerns** (i.e., bullying, wandering, water) at this visit?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No
6. Did you screen for **behavior concerns** (e.g., anxiety, ADHD, irritability) at this visit?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No

Section 2: **MEDICATION DECISION SUPPORT**

1. Did you screen for medication side effects by asking parent/patient about their experience?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No
2. Did you review vital signs (e.g., Ht, Wt, BP, HR) to assess medication affect and/or side effects?	Yes	No
a. If so, did you discuss and document in your note?	Yes	No
3. If lab monitoring is needed for medications, has it been completed in the expected time frame? (e.g., atypical antipsychotics – monitoring standards)	Yes	No
a. Is adherence to or deviation from standard monitoring documented in your note?	Yes	No

Section 3: **PREVENTATIVE VISITS**

1. Did the patient have all vital signs (e.g., HT, WT, BP, HR) recorded for their visit?	Yes	No
a. If not, was the reason they were not obtained documented?	Yes	No
2. Did you follow Bright Futures Preventative Guidelines (0-21) for this age visit? (e.g., hearing, vision, immunizations, anticipatory guidance) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf	Yes	No
a. If not, was the reason documented (i.e., patient unable to complete vision/hearing screening, parents not interested in vaccines, modifications made to anticipatory guidance for developmental age)	Yes	No
b. If not completed due to patient needing more support, did you refer for additional support (i.e., audiology, pediatric optometrist, behavior support in your office) to ensure they receive standard preventative care for their age?	Yes	No
3. Is this patient aged 12 or older?	Yes	No
a. Did you discuss transition to adulthood (e.g., puberty, healthcare, post-secondary life) topics relevant to the child/family at this visit?	Yes	No
b. Did you provide transition resources to the child/caregivers at this visit (i.e., https://echoautism.org/transition-to-adulthood/ or https://echoautism.org/puberty-and-self-care/)	Yes	No
4. Is this patient aged 18 or older?	Yes	No
a. Are they their own guardian?	Yes	No
b. If not, do you have a copy of guardianship or power of attorney paperwork on file?	Yes	No
c. If yes, do you have the patients signed permission to speak with their caregiver/parents?	Yes	No