Rady Children's

Autism-Friendly Health System Initiative

Autism-Friendly Questionnaire (AFQ)

Name: _____

Date of Birth: _____

The purpose of this questionnaire is to provide information to your child's care team so that they can partner with you to create a more comfortable experience for your child. You are being asked to complete this questionnaire because our records indicate that your child has an autism spectrum disorder (ASD) diagnosis. This questionnaire may also benefit children who are at risk of autism or who have specific communication or sensory needs.

For each question, please choose *all* responses that apply to your child.

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1. Relationship of Person Completing Questionnaire

❍ Patient ❍ Father ❍ Mother ❍ Legal Guardian

❍ RCHSD employee working with patient (name/title):_____

❍ Other caregiver (*please specify*): _____

2. How does your <u>child communicate</u> with others to get their basic needs met

❍ Talking (Conversation) ❍ Writing it down ❍ Sign Language

❍ Talking (Short phrases) ❍ iPad/tablet ❍ Pictures

❍ Other (*please specify*): _____

3. What is the best way for <u>medical staff</u> to communicate with your child

❍ Talking (Conversation) ❍ Writing it down ❍ Sign Language

❍ Talking (Short phrases) ❍ iPad/tablet ❍ Pictures

❍ Other (*please specify*):_____

4. What might cause your child to be nervous or upset

❍ Lights ❍ Smells ❍ Tastes/Textures ❍ Medications ❍ Sounds ❍ Touch

❍ A lot of people ❍ Tape/Band-aids ❍ Transitions/changing activities ❍ Waiting

❍ Small room/space ❍ Being told "no" ❍ Hospital Clothing ❍ Needles

❍ Specific Phrases or words (*please specify*): _____

❍ Vitals_____ ❍ Other (*please specify*):_____

5. What are early signs your child is nervous or upset

❍ Flapping arms ❍ Rocking back and forth ❍ Not following directions

❍ Moving away from people ❍ Tightening jaws or fists ❍ Talking about a specific topic a lot

❍ Fidgeting/moving ❍ Walking back and forth ❍ Repeating words or phrases

❍ Yelling ❍ Avoiding eye contact ❍ Hurting Self

❍ Other (please specify)_____

Autism-Friendly Questionnaire (AFQ) *Continued*

6. What are helpful techniques to support a positive experience for your child's visit?

❍ Bubbles ❍ Weighted vest/blanket ❍ Keep noise levels low ❍ Headphones
❍ Self-soothing behavior ❍ Music ❍ iPad ❍ Fidget toys
❍ Give warning before changes ❍ Allow time to think about questions/instructions
❍ Pressure/squeezes ❍ Model of any procedures ❍ Simple direct language
❍ Provide 2-3 choices when offering items/activities ❍ Medication ❍ Picture Schedule
❍ Turn lights down ❍ Reward after procedure ❍ Written Schedule ❍ Private waiting area
❍ Distraction during procedure ❍ Other (please specify)_____

7. Does your child have any specific behaviors that we should know about?

❍ Strong focus on an object/activity/topic ❍ Doing the same thing over and over ❍ Running/escaping
❍ Hurting others ❍ Hurting self ❍ Rocking back and forth
❍ Grabbing items ❍ None ❍ Other (please specify)_____

8. How does your child demonstrate/communicate pain?

❍ Using words ❍ Crying ❍ Facial expressions ❍ Using a pain scale ❍ Body language
❍ Pointing ❍ Withdrawing ❍ iPad/tablet ❍ Not doing daily activities
❍ Other (please specify)_____

9. What are your child's favorite activities/objects or rewards/favorite topics? *(Please be specific in comments)*

❍ Electronics ❍ Reward chart ❍ Food/snacks/drinks ❍ Books ❍ Toys/activities
❍ Music:_____
❍ Favorite topics (please specify):_____
❍ Other (please specify)_____

10. Is there anything specific you would like us to know about your child's previous medical experience(s), i.e., things that went well, things that could be improved upon by staff to best meet the needs of your child?

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