

Autism Observation Summary Report

Autism Coordinator:

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| Date: |  | School: |  |
| Student name: |  | ID#: |  |
| Date of birth: |  | Grade: |  |

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| **Observation Information** | |
| Observer name |  |
| Observer # |  |
| Date |  |
| Day of week |  |
| Time |  |
| Class/setting |  |
| No. of students |  |

When summarizing your observation, please describe what the behavior looks like, giving examples when appropriate, rather than stating only if the behavior was exhibited. If the student’s behavior was seen as typical, please again give examples substantiating this typical behavior.

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| **Description of Activity** | |
| Student’s level of participation in comparison to the class |  |
| Possible academic difficulties |  |
| Possible academic strengths |  |

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| **Impairments Social Interaction** | |
| Non-verbal communication skills (usage/interpretation of non-verbal communication) |  |
| Description of peer relationships (the ability/desire to interact) |  |
| Social cues (ability to identify/interpret social thinking) |  |

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| **Impairments in Communication** | |
| Ability to initiate/sustain/end a conversation |  |
| Prosody (pitch, intonation, rhythm of voice) |  |
| Stereotyped/repetitive use of language |  |
| Make-believe play or social imitative play |  |

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| **Restrictive, Repetitive and Stereotyped Behavior/Interests/Activities** | |
| Preoccupation with stereotyped/restricted patterns or interest |  |
| Inflexible adherence to specific/nonfunctional/  routines/rituals/  obsessions |  |
| Stereotyped and repetitive motor mannerisms |  |
| Persistent preoccupation with parts of objects |  |

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| **Behavioral Difficulties/Strengths** | |
| Reaction to stress/anxiety and possible causes |  |

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| **Motor Functioning and Planning Skills** | |
| Gross motor skills |  |
| Fine motor skills |  |

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| **Executive Functioning** | |
| Organization |  |
| Planning/execution |  |
| Sustaining of attention/ distractibility (differences in individual vs. group activity) |  |

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| **Sensory Sensitivities/Oddities if Observed** | |
| Gustatory (foods) |  |
| Visual |  |
| Olfactory (smell) |  |
| Auditory (sounds) |  |
| Tactile (touch/space) |  |

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| **Summary** |
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Individual evaluation was conducted in the student’s native language or other communication mode used by the student:

Yes

No

Evaluator’s initials: