Agency Program Name: ___________________________ KIDS Child ID# ________________

Child’s Legal First Name _____________________ Legal Last Name ________________________________

Age for ASQ:SE-2: _______

1. Date Child ASQ:SE-2 Survey Completed: ______/____/____  MM/DD/YYYY

2. Was the questionnaire age-adjusted due to prematurity?
   ○ Yes  ○ No

3. Area   Total Score
   ASQ:SE-2   __________

4. Follow-up action taken, check all that apply:
   ○ Provide activities and rescreen in months (specify months)
   ○ Refer to primary health care provider or other community agency (specify reason)
   ○ Refer to early intervention/early childhood special education.
   ○ No further action taken at this time.
   ○ Other

   Rescreen in __________ months.

   Referral Reason: __________________________________________________________________________

   Other ____________________________________________________________________________________

5. If you referred the child for further testing, did the family access the recommended services?
   ○ Yes  ○ No

6. If the family did not access recommended services, check all of the following that apply:
   ○ Family declined further services.
   ○ Family opts out for religious or other medical reasons.
   ○ Family lacks access to services (i.e. distance for treatment, lack of transportation, etc.)
   ○ Additional testing is cost prohibitive.
   ○ Other ____________________________________________________________________________________