Agency Program: __________________________ KIDS Child ID# __________________________

Child’s Legal First Name ___________________ Legal Last Name __________________________

Select Age for ASQ:SE: ______

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

2. Was the age adjusted for prematurity when selecting the questionnaire?
   ○ Yes  ○ No

3. Area Total Score
   ASQ:SE __________

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 a referral was made, did the family access recommended services for this child?
   ○ 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 ______________________________________________________________________________