

# Comparing Treatment Methods & Providers

Adapted from: *Does My Child Have Autism?* By Wendy L. Stone, Ph.D. with Theresa Foy DiGeronimo

PROGRAM	
Name of Program/Provider	
Method	
Location Phone Number Email Website	
Hours per Week	
Cost	
Reimbursement	
Recommended by	
PROGRAM CONTENT	
Areas of development focused on: (language, communication, toy play, imitation, peer play, social interactions, behavior, pre-academic skills, work skills, parent training)	
How specific goals are identified for each child:	
How behaviors and skills are prioritized:	
What kind of teaching is used:	
How behaviors are managed:	
MEASURING PROGRESS	
How will I know if my child is making progress?	
How long will it be before I see changes?	
What types of improvements should I expect?	
How often will you assess progress & how is it measured?	

What will happen if my child doesn't make progress with this treatment?

### THERAPIST QUALIFICATIONS

How many children with Autism have you worked with?  
What ages?

Do you serve children over three years old?

What are your qualifications?  
What type of training do you have?

Do you have a professional degree or certificate  
(Ask for details)

Are you affiliated with a professional organization?  
(Ask for details)

What do you see as your strongest skills in working with children with Autism?

Are there issues or problems you consider to be outside of your realm of expertise?

### SCIENTIFIC EVIDENCE OF EFFECTIVENESS

Is there research to support the effectiveness of this type of treatment?  
(Ask for details as well as copies of published articles)

Has research shown this treatment to be better than other types of treatment?

### PROFESSIONAL INVOLVEMENT

Who will be providing the direct intervention with my child?

What type of training do they have?

Who will be supervising them and how?

How often will you see my child personally?

**PARENT INVOLVEMENT**

Will I be able to participate in the treatment?

Will you teach me to work with my child? How?

What skills will you teach me?  
(Ask for examples)

**COMPATIBILITY WITH OTHER TREATMENTS**

How many hours per week of your treatment will my child need?

Is your treatment compatible with other interventions my child is participating in?

How do you collaborate with other therapy providers on my child's team?  
(get examples)





# CONTACTS - Medical

Specialty	Neurology
Name of Contact	Dr. Sample Doctor
Name of Practice	Children's Hospital
Phone Number	(508)555-1000
Address	2000 Summit Drive Anytown, MA 01000
Email Address/ Website	sample.doctor@childrens.edu
Specialty	
Name of Contact	
Name of Practice	
Phone Number	
Address	
Email Address/ Website	
Specialty	
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Name of Practice	
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# CONTACTS - Therapy

Specialty	Neurology
Name of Contact	Dr. Sample Doctor
Name of Practice	Children's Hospital
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Specialty	
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Name of Practice	
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# CONTACTS - Support

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Name of Contact	Dr. Sample Doctor
Name of Practice	Children's Hospital
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Address	2000 Summit Drive Anytown, MA 01000
Email Address/ Website	sample.doctor@childrens.edu
Specialty	
Name of Contact	
Name of Practice	
Phone Number	
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# CONTACTS - Other

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# Phone Log

Name of Contact	
Phone Number	
Date/Time	
Summary of Call	
Follow up Required	
Date/Time	
Summary of Call	
Follow up Required	
Date/Time	
Summary of Call	
Follow up Required	
Date/Time	
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Date/Time	
Summary of Call	
Follow up Required	



# Assessment Tracking

Type of Therapy:

Date	Test Administered	Evaluator	Standard Score	Age Equivalent	Change in Standard Score	Change in Age Equivalent
1/12/07	Oral & Written Language Scales (Subtest) Oral Expression (Subtest) Listening Comprehension	Ms. Smith	49 48	3.4 3.5		
2/8/08	Oral & Written Language Scales (Subtest) Oral Expression (Subtest) Listening Comprehension	Ms. Jones	50 57	3.8 4.1	1 9	4 months 8 months
	Team Meeting/Review		10	2	1	







