

We all communicate differently. We hope that by completing this form, your Emergency Department visit will be smoother. **Please check all applicable responses. This form is to be completed by the parent or guardian of the child.**

***This is My Child Questionnaire***

*\*This form is based on work from the Hospital for Sick Children in Toronto*

Name child prefers to be called or will respond to:

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| HOW MY CHILD **COMMUNICATES:** |
| □ | Verbally |
| □ | Electronic device (iPad) |
| □ | Pictures |
| □ | Writing |
| □ | Typing |
| □ | Sign Language |
| □ | Gestures or points |
| □ | Communicates only with parent directly |
| □ | Facial expression |

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| --- | --- |
| **CALMING** ITEMS/STRATEGIES: | Did you bring them? |
| □ | Headphones/listening tomusic/earplugs | □ Y or □ N |
| □ | Weighted vest | □ Y or □ N |
| □ | Blankets | □ Y or □ N |
| □ | Sunglasses | □ Y or □ N |
| □ | Stress balls | □ Y or □ N |
| □ | Preferred item (e.g., toy) | □ Y or □ N |
| □ | Presence of a sibling | □ Y or □ N |
| □ | Support person → | □ Y or □ N |

Who?

|  |  |  |
| --- | --- | --- |
| □ | Separate Room | n/a |
| □ | Parental holding | n/a |
| □ | Other → |  |

Describe:

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| POTENTIAL **TRIGGERS THAT ELICIT EXTREME BEHAVIOUR:** |
| □ | Bright lights, flickering lights |
| □ | Sudden or loud noises |
| □ | Crowds/multiple people in the same space |
| □ | Being touched |
| □ | Smells (specify): |
| □ | Fabrics, textures (specify): |
| □ | Visual stimulation (specify): |
| □ | Transitions |
| □ | Not applicable |

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| HOW MY CHILD **EXPRESSES PAIN:** |
| □ | Cries |
| □ | Screams |
| □ | Touches or points to painful body part or area |
| □ | Verbally articulates pain |
| □ | Self-injury |
| □ | Aggression towards others |
| □ | Looks quiet/calm |
| □ | Is physically active (e.g., pacing, running around) |

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| WHAT MIGHT HELP WITH **MEDICAL EXAMS/PROCEDURES?** |
| □ | Describe the procedure to my child beforehand |
| □ | Allow child to see equipment beforehand |
| □ | List of steps |
| □ | Practicing the steps |
| □ | Picture sequences |
| □ | No pre-warning. Do the procedure without warning |
| □ | Distraction |
| □ | May require sedation |
| □ | Numbing cream |
| □ | I do not know |

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| DOES YOUR CHILD HAVE ANY **DEVELOPMENTAL / BEHAVIOURAL** **CHALLENGES**? □ Y or □ N |

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| DOES YOUR CHILD HAVE ANY **SPECIFIC DEVELOPMENTAL / BEHAVIOURAL** **DIAGNOSES**? □ Y or □ N |
| If YES, select the appropriate answers from the list: |
| * Autism Spectrum Disorder □ Cerebral Palsy
* Down Syndrome □ Fetal Alcohol Spectrum Disorder
* Communication Disorder □ Intellectual Disability
* Motor Disorder □ Attention Deficit Hyperactivity Disorder
* Other:
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| --- | --- | --- |
| □ | Not applicable | n/a |

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| Would you like to be referred to someone who can help you access **Support Services**? □ Y or □ N |

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| --- | --- |
| WHAT HELPS WITH **WAITING?** | Did you bring them? |
| □ | Timers or clocks | □ Y or □ N |
| □ | Schedules or lists | □ Y or □ N |
| □ | Preferred items | □ Y or □ N |
| □ | Distraction | □ Y or □ N |
| □ | Other: | □ Y or □ N |

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| DOES YOUR CHILD HAVE ANY **ADDITIONAL DEVELOPMENTAL /** **BEHAVIOURAL CONCERNS**? □ Y or □ N |
| If YES, select the appropriate answers from the list: |
| * Easily anxious □ Shy □ Easily overstimulated
* Behavioural challenges □ Highly active
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| HOW MY CHILD **UNDERSTANDS OTHERS:** |
| □ | Spoken language |
| □ | Text (written or typed) |
| □ | Sign language |
| □ | Pictures |
| □ | Lists |
| □ | Communicates only with parent directly |
| □ | Too young |

 Other Comments?