

Resource use questionnaire – parent/guardian



We would like to understand your child’s use of services, excluding any Social Stories™. This will help us understand how much support your child gets in different places.

- a. If you are not sure about the service name, then please select the one you think is the closest match.
- b. All appointments or visits should be counted only ONCE.

General health and community services

Has your child accessed any of the following in the last 6 months? (please cross all that apply)

<input checked="" type="checkbox"/> Service	Number of appointments attended		
	At home	At clinic/ surgery	Via phone/ email
<input type="checkbox"/> General Practitioner (GP)	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Community Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Community Paediatrician	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Social care worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Home care worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Family support worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Drug and alcohol support worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Helpline (e.g. Samaritans)	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Occupational therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Physiotherapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Speech and Language Therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Youth worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Other (please specify):	<input type="text"/>	<input type="text"/>	<input type="text"/>

Has your child accessed any of the following respite and sharing care community-based services in the last 6 months? (please cross all that apply)

<input checked="" type="checkbox"/>	
<input type="checkbox"/> Overnight stay in respite centre / Local Authority house	<input type="text"/> nights
<input type="checkbox"/> Overnight stay with another family / sharing care / PACT stay	<input type="text"/> nights
<input type="checkbox"/> Day stay with another family / sharing care / PACT support	<input type="text"/> days

**Education services**

Has your child accessed any of the following educational services in the last 6 months?
(please cross all that apply)

<input checked="" type="checkbox"/>	Number of hours per week	
	At home	At clinic/surgery
<input type="checkbox"/> Educational psychologist	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Education welfare officer	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> School nurse	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Specialist teacher advisor (e.g. for autism)	<input type="text"/>	<input type="text"/>

Mental health services

Has your child had any appointments with the **Child and Adolescent Mental Health Services (CAMHS)** in the last 6 months? (Please do not count visits or appointments included in the previous tables.) (please cross all that apply)

<input checked="" type="checkbox"/>	Number of sessions
<input type="checkbox"/> Child psychiatrist	<input type="text"/>
<input type="checkbox"/> Child psychotherapist	<input type="text"/>
<input type="checkbox"/> Child psychologist or clinical psychologist	<input type="text"/>
<input type="checkbox"/> Mental health nurse or CAMHS therapist	<input type="text"/>
<input type="checkbox"/> Family therapist	<input type="text"/>
<input type="checkbox"/> Wellbeing worker	<input type="text"/>
<input type="checkbox"/> Other (please specify): _____	<input type="text"/>

Has your child received any other mental health service in the last 6 months? (Please do not count visits or appointments included in the previous tables.) (please cross all that apply)

<input checked="" type="checkbox"/>	Number of sessions
<input type="checkbox"/> Charity support worker	<input type="text"/>
<input type="checkbox"/> GP counselling	<input type="text"/>
<input type="checkbox"/> School or other counsellor	<input type="text"/>
<input type="checkbox"/> Privately paid mental health service (please specify): _____	<input type="text"/>
<input type="checkbox"/> Other (please specify): _____	<input type="text"/>



Other services

Has your child accessed any other services in the last 6 months? (please cross all that apply)



Number of sessions

Paid childcare (half day = 1 session)

Other (e.g. Saturday clubs)

(please specify):

Hospital-based services

Has your child accessed any of the following urgent hospital services for any health issue, in the last 6 months? (please cross all that apply)



Number of visits

Was the visit related to autism or any treatment for autism?

Accident and Emergency (excluding urgent care/ minor injuries unit)

Yes No Unsure

NHS walk-in centre (specify whether 111 call or attendance at centre)

Yes No Unsure

Urgent care centre/ minor injuries unit (excluding A&E attendance or walk-in-centre visits)

Yes No Unsure

Other

(please specify):

Yes No Unsure

Has your child had any non-urgent visits to hospital for any health issue, in the last 6 months?

	Details	Day case or overnight stay?	Total nights (if overnight stay)	Was the visit related to autism or any treatment for autism?
1.	<input type="text"/>	<input type="checkbox"/> Outpatients <input type="checkbox"/> Day case <input type="checkbox"/> Overnight stay	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
2.	<input type="text"/>	<input type="checkbox"/> Outpatients <input type="checkbox"/> Day case <input type="checkbox"/> Overnight stay	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
3.	<input type="text"/>	<input type="checkbox"/> Outpatients <input type="checkbox"/> Day case <input type="checkbox"/> Overnight stay	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
4.	<input type="text"/>	<input type="checkbox"/> Outpatients <input type="checkbox"/> Day case <input type="checkbox"/> Overnight stay	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
5.	<input type="text"/>	<input type="checkbox"/> Outpatients <input type="checkbox"/> Day case <input type="checkbox"/> Overnight stay	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure



Has your child taken any regular medications in the last 6 months (not including painkillers e.g. paracetamol)? Yes No (If 'Yes', please complete the table below)

	Medication start	Medication finish
1. Medication name <input type="text"/> Dose and unit (e.g. 200mg, 1g etc.) <input type="text"/> Frequency (e.g., daily, twice daily, as required) <input type="text"/>	Started >6 months ago <input type="checkbox"/> Start date (if started <6 months ago) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>	Ongoing <input type="checkbox"/> Stop date (if not ongoing) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>
2. Medication name <input type="text"/> Dose and unit (e.g. 200mg, 1g etc.) <input type="text"/> Frequency (e.g., daily, twice daily, as required) <input type="text"/>	Started >6 months ago <input type="checkbox"/> Start date (if started <6 months ago) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>	Ongoing <input type="checkbox"/> Stop date (if not ongoing) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>
3. Medication name <input type="text"/> Dose and unit (e.g. 200mg, 1g etc.) <input type="text"/> Frequency (e.g., daily, twice daily, as required) <input type="text"/>	Started >6 months ago <input type="checkbox"/> Start date (if started <6 months ago) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>	Ongoing <input type="checkbox"/> Stop date (if not ongoing) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>
4. Medication name <input type="text"/> Dose and unit (e.g. 200mg, 1g etc.) <input type="text"/> Frequency (e.g., daily, twice daily, as required) <input type="text"/>	Started >6 months ago <input type="checkbox"/> Start date (if started <6 months ago) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>	Ongoing <input type="checkbox"/> Stop date (if not ongoing) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>
5. Medication name <input type="text"/> Dose and unit (e.g. 200mg, 1g etc.) <input type="text"/> Frequency (e.g., daily, twice daily, as required) <input type="text"/>	Started >6 months ago <input type="checkbox"/> Start date (if started <6 months ago) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>	Ongoing <input type="checkbox"/> Stop date (if not ongoing) <i>ddmmyyyy</i> <input type="text"/> / <input type="text"/> / <input type="text"/>



Has your child been absent from school (excluding school holidays) in the last 6 months?

(please cross one box only)

Yes No



How many days were missed?

Have you been in employment/education/training in the last 6 months?

(please cross all that apply)

<input checked="" type="checkbox"/>	Job title (if applicable)	Full/part time	Have you missed any days to care for your child?	Days missed
<input type="checkbox"/> Paid employment	<input type="text"/>	<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Unpaid employment	<input type="text"/>	<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Education/training	<input type="text"/>	<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

Has your partner been in employment/education/training in the last 6 months?

(please cross all that apply)

<input checked="" type="checkbox"/>	Job title (if applicable)	Full/part time	Have you missed any days to care for your child?	Days missed
<input type="checkbox"/> Paid employment	<input type="text"/>	<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Unpaid employment	<input type="text"/>	<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Education/training	<input type="text"/>	<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

Have you accompanied your child to health or other services in the last 6 months?

(please cross one box only)

Yes No



Which services were accessed?

Resource use questionnaire – teacher



Has the child received any of the following interventions/support in the last 6 months?
(please cross all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Applied Behavioural Analysis (ABA) | <input type="checkbox"/> Social Stories™ |
| <input type="checkbox"/> Art therapy | <input type="checkbox"/> Social Use of Language Programming (SULP) |
| <input type="checkbox"/> Discrete trial training | <input type="checkbox"/> Social-Communication, Emotional Regulation and Transactional Support (SCERTS model) |
| <input type="checkbox"/> Drama therapy | <input type="checkbox"/> Son-Rise program |
| <input type="checkbox"/> ELSA (or equivalent) sessions | <input type="checkbox"/> Structure, Positive (approaches and expectations), Empathy, Low arousal, Links (SPELL approach) |
| <input type="checkbox"/> Functional communication training | <input type="checkbox"/> Theory of mind training |
| <input type="checkbox"/> Intensive interaction | <input type="checkbox"/> Treatment and Education of Autistic and Communication-Handicapped Children (TEACCH) |
| <input type="checkbox"/> LEGO®-based therapy | <input type="checkbox"/> Verbal behaviour approach |
| <input type="checkbox"/> Music therapy | <input type="checkbox"/> Video modelling |
| <input type="checkbox"/> Picture Exchange Communication Systems (PECS) | <input type="checkbox"/> Visual schedules |
| <input type="checkbox"/> Relationship Development Intervention (RDI) | <input type="checkbox"/> 1:1 mentoring/ individual work |
| <input type="checkbox"/> Responsive teaching | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Social Communication groups (e.g. Time to talk) | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| <input type="checkbox"/> Social skills work group (more than usual care as usual groups) | |

For each intervention/support crossed above, please complete a row per provider in the table below:

Intervention / support	Provided by*	Number of sessions in last 6 months	Average session duration (mins)	Are you aware of any associated hospital admissions?	
1. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> mins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> mins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> mins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> mins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> mins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> mins	<input type="checkbox"/> Yes	<input type="checkbox"/> No

* T Teacher/educator
 TA Teaching assistant
 HLTA Higher Level Teaching Assistant
 SENCO Special Educational Needs Co-ordinator
 LM Learning Mentor

ELSA Emotional Literacy Support Assistant
 HT Head teacher / senior member of staff
 O Other (specify above)
 STA Specialist teacher advisor
 EP Educational Psychologist



In the last 6 months, are you aware of the child being admitted to hospital due to any of the interventions listed on page 5?

Admission details	Date of admission (dd/mm/yyyy)	Length of stay
1. <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>day month year</small>	<input type="text"/> nights
2. <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>day month year</small>	<input type="text"/> nights
3. <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>day month year</small>	<input type="text"/> nights

How many children are usually in the child's class (including the child)? children

Who has been involved in supporting the child in class in the last 6 months?

(only include individual/1:1 assistance in usual classroom lessons) please cross all that apply and provide the additional information.

Support provided by	Number of individuals providing support	Whole Time Equivalent (WTE)	OR	Hours with the child in a week
<input type="checkbox"/> Teacher / Educator	<input type="text"/>	<input type="text"/> . <input type="text"/> WTE		<input type="text"/> hrs <input type="text"/> mins
<input type="checkbox"/> Teaching Assistant	<input type="text"/>	<input type="text"/> . <input type="text"/> WTE		<input type="text"/> hrs <input type="text"/> mins
<input type="checkbox"/> Other (specify) <input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/> WTE		<input type="text"/> hrs <input type="text"/> mins
<input type="checkbox"/> Other (specify) <input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/> WTE		<input type="text"/> hrs <input type="text"/> mins
<input type="checkbox"/> Other (specify) <input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/> WTE		<input type="text"/> hrs <input type="text"/> mins
<input type="checkbox"/> Other (specify) <input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/> WTE		<input type="text"/> hrs <input type="text"/> mins
<input type="checkbox"/> Other (specify) <input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/> WTE		<input type="text"/> hrs <input type="text"/> mins

Has the child's behaviour disrupted lessons to the point where they had to be removed from class over the last 6 months? (please cross one box only)

Yes No



- How many times? times

- On average, how long does it take to stop the disruption in class? minutes