for office use only
Reg. No. .....

Sunbeam
SAC AUTISM CENTRE
Helping you raise a child with Autism

Lahartara, Varanasi

Admission Form

Date: _____

1. Name of the child : _____
2. Date of Birth: _____ Sex: _____
3. Father's Name: _____
4. Address : _____

   _____

   _____
5. Phone : (M) _____ (R) _____ (LL) _____
6. Diagnosis: _____

   _____
7. Email ID : _____
8. Family:

(b) Father	(a) Mother
Name : _____	Name : _____
Age : _____ Education : _____	Age : _____ Education : _____
Occupation _____	Occupation _____
General Health : _____	General Health : _____
Blood Group : _____	Blood Group : _____
Income : _____	Income : _____

(c) Siblings

Name:	Age/Sex :	Education/Occupation
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

4. _____

Housing Condition

Joint family ☐ Nuclear Family ☐ (please tick)

9. Number of people staying in the house _____

They are (Please mention the relation to child in Hindi)

_____

_____

10. Family history of any disorder _____
11. Consanguinity _____

To be filled by RCI approved developmental psychologist/consultant

12. Medical Information

a. Natal

Place of delivery _____

Type of delivery _____

Time of delivery (Full term/Pre mature) _____

Birth cry (Immediate/Delayed) _____

APGAR score _____

Medical problems (Jaundice/Convulsion/Diarrhoea) _____

Congenital Disorders _____

Difficulty in sucking _____

b. Post-natal

Infection _____ Injury _____

Fever/Meningitis _____ Convulsions _____

Diarrhoea/Jaundice _____ Any other _____

13. Details of Convulsions

Date of first Convulsions _____ Date of last Convulsions _____

Usual frequency _____ Usual duration of each Convulsions _____

Medicines : Past/Present _____ _____ _____

Name of the Neurologist _____

Description of the Convulsions _____

14. Special investigations

CT-Scan/MRI _____ EEG/EMG _____

Ultrasound/X-ray _____ Vision test _____

Vision test _____ Hearing test _____

Chromosomal study : _____ Others : _____

15. Immunizations (In Order):

a. _____

b. _____

c. _____

d. _____

16. Associated problems _____

17. Diagnosis _____

_____

_____

_____

Name of the Consultant **Signature of the Consultant**

_____ _____

Name of the Parents **Signature of the Parents**

_____ _____