CADDRE Services and Treatment Interview

SECTION A: Classroom programs
Many children participate in classroom based preschool programs:

A1. Has **[CHILD]** attended classroom programs in the past?
    YES 1   **NO 2**   **RF 8**   **DK 9**

A2. When did he/she begin attending a classroom program? (MM/YYYY)
__ __ /__ __ __ __

A3. Does **[CHILD]** currently attend a classroom program?
    YES 1   **NO 2**   **RF 8**   **DK 9**

A4. When did he/she stop attending the classroom program? (MM/YYYY)
__ __/ __ __ __ __

A5. How many children are in **[CHILD'S]** class?

A6. Does **[CHILD]** have a 1:1 aide or a shadow full time or part-time?
    Full time 1   **Part time 2**   **RF 8**   **DK 9**

A7. How many days per week does your child attend this school program?
____ days

A8. How many hours per day does your child attend this school program?
____ hours

A9. Is this a special program that is related to your child's disability?
    YES 1   **NO 2**   **RF 8**   **DK 9**

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<u>SECTION B: Professional Individual and Group Services</u>

A10. Now, I'd like to know if your child has <u>ever</u> used any of the following **services** to meet his/her developmental needs?
> *Note to interviewer – services can be received anytime, either in/outside of school.*

Services	**YES**	**NO**	**RF**	**DK**
Behavior modification	1	2	8	9
Occupational therapy	1	2	8	9
Physical therapy	1	2	8	9
Respite care	1	2	8	9
Sensory Integration therapy	1	2	8	9
Social Skills training	1	2	8	9
Speech therapy	1	2	8	9
Vision services	1	2	8	9
Other (specify and rate)	1	2	8	9

_____
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_____
_____
_____
_____

Note to interviewer – skip A11 if YES is not marked at least once in A10.
A11. How many **service** hours does your child <u>currently</u> receive per week?
_____ Hours per week

A12. Now, I'd like to know if your child has <u>ever</u> seen any of the following **service providers** for his/her developmental needs?
> *Note to interviewer – providers can be either in/outside of school.*

Service Providers	**YES**	**NO**	**RF**	**DK**
Audiologist	1	2	8	9
Developmental Pediatrician	1	2	8	9
Case manager	1	2	8	9
Chiropractor	1	2	8	9
Neurologist	1	2	8	9
Nutritionist	1	2	8	9
Nurse (home/long-term care)	1	2	8	9
Paraprofessional (_____indicate type)				
	1	2	8	9
Psychiatrist	1	2	8	9
Psychologist	1	2	8	9
Social worker	1	2	8	9
Other (specify and rate)	1	2	8	9

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Note to interviewer – skip A13 if YES is not marked at least once in A12.

A13. How many hours per week does your child <u>currently</u> work with these **service providers**?

_____ Hours per week

<u>SECTION B: Complementary and Alternative Medicines (CAM), Therapies, Interventions</u>

B1. Please describe what special diets, vitamins, food supplements, alternative treatments [including over-the-counter medications, prescriptions, or special injections to treat your child's developmental problems], or interventions your child has <u>ever</u> received that were not previously reported.

Interviewer Note - refer respondent to List 11f-g (Alternative treatments and Herbal medications) in the prep guide. **Write down ALL parent responses verbatim** *:*

Med/TX 1:
Med/TX 2:
Med/TX 3:
Med/TX 4:
Med/TX 5:
Med/TX 6:
Med/TX 7:
Med/TX 8:
Med/TX 9:
Med/TX 10:

B2. What special diets, vitamins, food supplements, alternative treatments [including over-the-counter medications, prescriptions, or special injections to treat your child's developmental problems], or interventions is your child currently receiving that were not previously reported?

Interviewer Note - refer respondent to List 11f-g (Alternative treatments and Herbal medications) in the prep guide. **Write down ALL parent responses verbatim** *:*

CAM, Therapy, Intervention Currently Receiving:	**YES**	**NO**	**RF**	**DK**
_____	1	2	8	9
_____	1	2	8	9
_____	1	2	8	9
_____	1	2	8	9
_____	1	2	8	9
_____	1	2	8	9

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1	2	8	9
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