MARSHALL UNIVERSITY

www.marshall.edu

Please return to:
ASD Registry Coordinator
WV Autism Training Center
Old Main, Room 316
One John Marshall Drive
Huntington, WV 25755-2430
304-696-2332

West Virginia Autism Spectrum Disorder Registry

Patient Information:

First name initial _____ Last name initial: _____ Birth date: _____

Sex: M ☐ F ☐ City/town of birth: _____ State of birth: _____

WV City/town at time of diagnosis _____

Race/Ethnicity:

☐ White (Non-Hispanic)
☐ Black (Non-Hispanic)
☐ Hispanic
☐ Unknown
☐ American Indian / Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ Asian
☐ Other

Does this individual have siblings diagnosed with ASD? ☐ Yes ☐ No

If yes, list the ages of those siblings: Sibling 1: _____ Sibling 2: _____ Sibling 3: _____ Sibling 4: _____

Diagnostic Information:

(Select the diagnosis made for this patient)

☐ Autism Spectrum Disorder, Level 1
☐ Autism Spectrum Disorder, Level 2
☐ Autism Spectrum Disorder, Level 3
☐ Autistic Disorder
☐ Asperger's Disorder
☐ PDD-NOS

Diagnostician Information:

Name (First, MI, Last) _____

Degree (select one): ☐ M.D. ☐ D.O. ☐ Psy.D. ☐ Ph.D. ☐ M.A. ☐ M.S.

Other (please specify): _____License #: _____ Email: _____

Postal Address: _____
_____

Signature: _____ Date: _____