

Autism / Special Needs COVID Clinic Questionnaire

Patient Information

Patient Name: _____ Appointment Time: _____
DOB _____

Questions

When receiving the vaccine, would you like to stay in your vehicle, or come inside to a sensory sensitive environment? (living room type setting with low light, and sound)

☐ Vehicle ☐ Inside

Is the person with special needs on the autism spectrum, or have a different developmental disability?
(please specify if other)

☐ Autism ☐ Other:

What is the individual's primary mode of communication?

☐ Verbal ☐ Pictures ☐ Gestures ☐ Sign language ☐ Voice output device

Are there specific things we can do to help the person have a safe and successful experience?

Are there specific things we should avoid doing or saying?

Is there anything else you would like us to know?

We would like to send you pictures and a link to a video that may help you and the person with special needs know what to expect when receiving the vaccine. To what email address would you like us to send that information?

Email address:

Phone number:

Address: