

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

Public Reporting Burden Statement

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-

Appendix F3

SECTION B: Professional Individual and Group Services

A10. Now, I'd like to know if your child has ever 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

Note to interviewer – skip A11 if YES is not marked at least once in A10.

A11. How many **service** hours does your child currently receive per week?

_____ Hours per week

A12. Now, I'd like to know if your child has ever 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

