

M-CHAT-R

Name: _____ Date: _____

Instructions

Please respond to the questions based on your child's typical behaviors. If a behavior is infrequent (e.g., you've observed it only once or twice), consider answering as if the child has not acquired the behavior.

| | Yes | No |
|---|--------------------------|--------------------------|
| 1. Can your child play appropriately with small toys, without just mouthing or dropping them? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your child bring objects to you to show you something? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does your child make eye contact with you for more than a second or two? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child seem oversensitive to noise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child smile in response to your face or smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does your child imitate your actions, like making faces back at you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child respond when you call their name? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. If you point to a toy across the room, does your child look at it? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Can your child walk independently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your child look at things you are looking at? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does your child make unusual finger movements near their face? | <input type="checkbox"/> | <input type="checkbox"/> |

| | | |
|--|--------------------------|--------------------------|
| 12. Does your child try to get your attention for their own activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever wondered if your child is deaf? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does your child enjoy activities like swinging or being bounced on your knee? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does your child show interest in playing with other children? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does your child like to climb on furniture or stairs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does your child enjoy playing peek-a-boo or hide-and-seek? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Does your child engage in pretend play, like talking on the phone or taking care of dolls? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Does your child use their index finger to point and ask for something? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Does your child use their index finger to point and show interest in something? | <input type="checkbox"/> | <input type="checkbox"/> |

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Scoring

Low-risk

Total Score 0-2; If the child is younger than 24 months, screen again after the second birthday. No further action required unless surveillance indicates a risk for ASD.

Medium Risk

Total Score 3-7; Administer the Follow-Up (second stage of M-CHAT-R/F) to gather additional information about at-risk responses. If the M-CHAT-R/F score remains at 2 or higher, the child has screened positive. Action required: refer the child for diagnostic evaluation and eligibility evaluation for early intervention. If the score on Follow-Up is 0-1, the child has screened negative. No further action is required unless surveillance indicates a risk for ASD. The child should be rescreened at future well-child visits.

High-risk

Total Score 8-20; It is acceptable to bypass the Follow-Up and refer the child immediately for diagnostic evaluation and eligibility evaluation for early intervention.