



Practice Name: \_\_\_\_\_

## Team Time - Screening Tool Selection

Are you currently using a screening tool? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is its name? \_\_\_\_\_

What do you like about your current method of screening?

What would you like to change about your current method of screening?

List advantages and disadvantages to your practice in using the following tools:

TOOL	ADVANTAGES	DISADVANTAGES
ASQ		
ASQ:SE		
PEDS		
TABS Screener		

*Please indicate with a check mark(s) the tool(s) that you choose to use in your practice.*

Do you need screening tools in English, Spanish, or both?

English \_\_\_\_\_ Spanish \_\_\_\_\_ Both \_\_\_\_\_

Please describe briefly your referral process for children identified with delays (please continue on back of this first sheet if needed).