



SMART PACKET



Lewis County Autism Coalition



Lewis County Autism Coalition
375 Linhart Ave NE, Suite B
Napavine, WA 98565
Phone: 253-421-3671
Website: www.lcautism.org

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Lewis County Autism Coalition
375 Linhart Ave NE, Suite B
Napavine, WA 98565
Phone: 253-421-3671
Website: www.lcautism.org

Dear Parent or Guardian,

Your child has been referred to Lewis County Autism Coalition due to concerns of possible Autism Spectrum Disorder (ASD). Please read and complete the enclosed materials to aid us in our assessment of your child. We require information concerning your child's medical, academic, family, and social history to properly evaluate for ASD.

Important Information:

- ◆ **All relevant paperwork MUST BE COMPLETED before the child can be evaluate**
- ◆ **If there is not enough information submitted your child's assessment can be delayed.**
- ◆ **Packets are processed in the order they are received.**

On the next page you will find a checklist outlining the necessary information to complete the packet. Please note:

- It is your responsibility to ensure the school/providers return any SMART tools (enclosed) or other forms to you prior to submitting the packet.
- Please only provide **copies** (no originals please) of reports such as report cards, evaluations or testing from medical professionals, academic plans or forms, etc.

Please bring the completed packet to LCAC

For other arrangements, please call: 253-421-3671



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Packet Checklist

FOR CHILDREN **UNDER 3 YEARS OLD:**

Included Forms:

- Authorization form release of records
- Demographics form
- Up to 3 SMART Tools – Give Two of them to a family member or someone familiar with your child. One of them is by a professional, teacher, daycare provider, speech therapist, etc.

Copies of the following: (no originals) (If applicable)

- Enroll patients in the Birth to 3 Program (Early Intervention/Support) based on your child's school district and include assessment results in the SMART packet.**
- If your child is at least 30 months old,** contact the COE medical provider for SRS-2 forms for the parent and teacher.
- Reports of any testing done by school psychologists, occupational, language, or physical therapists, including any developmental screenings
- Reports of previous evaluations by physicians, psychologists, or psychiatrists

FOR CHILDREN AGES **3 YEARS AND OLDER:**

Included Forms:

- Authorization form for the release of records
- Demographics form
- Up to 3 SMART Tools – Give Two of them to a family member or someone familiar with your child. One of them is by a professional, teacher, daycare provider, speech therapist, etc.

Copies of the following: (no originals)

- Report cards (past 2 years)
- Request educational assessment from the school district you live in and include assessment in packet. For Lewis County contact Lewis County Special Education Co-op at 1.360.748.3384.
- Contact LCAC** for SRS-2 forms for parent and teachers
- Reports of any testing done by school psychologists, occupational, language, or physical therapists, including any developmental screenings
- Copies of 504 plans or IEPs
- Reports of previous evaluations by physicians, psychologists, or psychiatrists



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Demographic Information

Date of Referral: _____ Person Referring: _____

Child's Name:	DOB:
Primary Language:	Secondary Language:
Interpreter Needed? YES / NO	
Parent/Guardian:	Relationship to Child:
Mailing Address: _____	
City:	State:
	Zip Code:
Primary Phone:	Secondary Phone:
School:	School District:
Teacher/Special Education Teacher:	Phone:
	FAX:
Birth to Three/Early Support:	Phone:
	FAX:
Physical Therapist/Phone Number/FAX:	Occupational Therapist/Phone Number/FAX:
Speech Therapist/Phone Number/FAX:	OTHER:



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School Medical Autism Review Team (SMART) Authorization for Release of Records

PURPOSE: As a parent/guardian, you have the right to give or not give permission for the release of your child’s records to other persons or agencies. By signing this authorization, you are giving permission to exchange confidential information for autism spectrum disorder screening purposes.

CHILD’S NAME: _____

DOB: _____

I hereby authorize the exchange of information orally, in writing, and/or electronically between the **School Medical Autism Review Team (SMART)** and the agencies/persons listed below:

Lewis County Autism Coalition
375 Linhart AVE NE, Suite B, Napavine, WA 98565 Phone: 253-421-3671 Fax: Email: outreach@lcautism.org
Primary Care Provider:
Early Intervention/Support Provider:
Daycare:
Therapist:
School District:
Other:
Other:

The records to be exchanged include:

Medical/Health History information / Evaluation/Assessment results, Developmental information/Educational Reports (Progress/IEP/504/IFSP), and any applicable School Records

This authorization is valid from _____ to _____. If not specified, this authorization is valid for one year from the date it was signed.

I understand that the information obtained will be treated in a confidential manner and I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent release.

Parent/Guardian Signature _____

Date _____

Patient Signature (if patient is 13 years of age or older) _____

Date _____



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Child's Name: _____ **DOB:** _____ **Today's Date:** _____
Name of person filling out form: _____ **Relationship to child:** _____

SMART TOOL

Social Communication & Interaction	True	False
Impairments in back-and-forth conversation (appropriate to language level) Example: Won't add something new or ask a question in response to a comment made to them.	<input type="checkbox"/>	<input type="checkbox"/>
Lack of, reduced, or impaired responses to social initiations of others. <i>Example: Doesn't respond to his/her name or acknowledge others.</i>	<input type="checkbox"/>	<input type="checkbox"/>
Lack or reduced use of gestures to communicate. <i>Example: Doesn't wave bye bye, nod yes or no, blow a kiss</i>	<input type="checkbox"/>	<input type="checkbox"/>
Impairments in the use of eye contact during social interactions. <i>Example: Looks to the side or at your mouth rather than your eyes when speaking to you.</i>	<input type="checkbox"/>	<input type="checkbox"/>
Deficits in the use of facial expressions to communicate. <i>Example: Doesn't frown, pout, look surprised.</i> Deficits in the use of facial expressions to communicate. <i>Example: Doesn't frown, pout, look surprised.</i>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of, or reduced interest in, peers (appropriate to developmental level)	<input type="checkbox"/>	<input type="checkbox"/>
Lack of, reduced, or impaired initiations of interactions with others	<input type="checkbox"/>	<input type="checkbox"/>
Reduced preference for some peers over others/impaired friendships	<input type="checkbox"/>	<input type="checkbox"/>
Delays in, or lack of, varied age-appropriate play with peers	<input type="checkbox"/>	<input type="checkbox"/>

Restricted, repetitive patterns of behavior, interests, & activities	True	False
Has atypical speech characteristics (e.g. echoing, jargon, unusual rhythm or volume)	<input type="checkbox"/>	<input type="checkbox"/>
Has repetitive body mannerisms	<input type="checkbox"/>	<input type="checkbox"/>
Reacts negatively to changes in schedule/insists on sameness	<input type="checkbox"/>	<input type="checkbox"/>
Has behavioral rituals	<input type="checkbox"/>	<input type="checkbox"/>
Has verbal rituals (e.g., must say things, or have others say things, in a particular way)	<input type="checkbox"/>	<input type="checkbox"/>
Has specific interests that are unusual in intensity (e.g., hobby of unusual intensity)	<input type="checkbox"/>	<input type="checkbox"/>
Engages in a limited range of activities/Has a limited behavioral repertoire	<input type="checkbox"/>	<input type="checkbox"/>
Shows hyper-reactivity to sensory input	<input type="checkbox"/>	<input type="checkbox"/>
Shows hypo-reactivity to sensory input	<input type="checkbox"/>	<input type="checkbox"/>
Shows unusual sensory interests and preferences	<input type="checkbox"/>	<input type="checkbox"/>

Disruptive Behavior	True	False
Engages in aggressive and/or destructive behaviors toward self, others, or objects (e.g. self-injury, elopement, property destruction)	<input type="checkbox"/>	<input type="checkbox"/>

Please leave comments on the backside of this page. Make copies if needed



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ASD Patient Information Form

Patient Name	DOB
Person completing form	Relationship
Daytime Phone	Work Phone
Current School/Phone	Grade
	Teacher Name

IMPORTANT: Please send these completed forms along with copies of report cards from recent grades completed, all psychological reports, and any counseling evaluations. Please complete all the information. After reviewing this information, our office will contact you with the next steps.

Present placement of child (please <input type="checkbox"/> appropriate box)	Adult with whom child is living >50% of the time	Adults not living in the home, but involved with child
Biological mother		
Biological father		
Step-mother		
Step-father		
Adoptive mother		
Adoptive father		
Relative (specify)		
Other (specify)		

Briefly state your concerns:

When did you first start having concerns? _____

What are your goals for this evaluation? _____

Has your child ever received the diagnosis of an autism spectrum disorder? YES NO

If yes in what month and year _____ and by whom _____



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School History

1. Please list schools attended in chronological order, starting with the most recent:

School	Grades Attended	City, State

2. Please comment on your child’s *academic* progress within each of these grade levels by writing **Good, Fair, Poor, or Not Applicable (N/A)** in the appropriate boxes.

	Pre- S	Kinder- garten	Grades 1-3	Grades 4-5	Grades 6-8	Grades 9-12
Relationship with peers						
Relationship with siblings						
Relationship with parents						
Relationship with teachers						
Overall school performance						
Behavior in school						
Participation in after school activities or sports						
Organizational skills						
Disrupting class						
Following directions/rules						
Homework completion						
Completing chores at home						



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3. To the best of your knowledge, at what grade level is your child functioning?

Reading

Math

Spelling

Above grade level	Above grade level	Above grade level
At grade level	At grade level	At grade level
Below grade level	Below grade level	Below grade level

4. Present class placement (circle): **regular class** *or* **special class** (if so, specify what kind of special class):

5. Has your child ever been in any other type of special education program, and if so, for how long? (if applicable)

Yes	No	Duration	Kind of special education program
			Learning disabilities class
			Behavioral disorders class
			Skills class led by social worker or school counselor
			Resource room
			Private tutoring or one-on-one aide
			Other (please specify):



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6. Have any additional educational modifications been attempted?

Yes	No	When	Type of instructional modification
			Private tutoring
			Behavioral modification program
			Daily or weekly progress report cards
			Class note taker assistance
			Books on tape for school texts
			Training and usage of computer

7. Please answer the following questions

Yes	No	When	Has your child ever...
			Been suspended from school?
			Been expelled from school?
			Repeated a grade?
			Had difficulty verbally expressing him/herself?
			Had difficulty understanding spoken directions?
			Had any speech difficulties or impediments?
			Had any speech or occupational therapy?

8. Please list any academic testing, psychological evaluations, and medical evaluations previously done for your child's learning problems (BASC, STAT, MCHAT, ASQ, MAT, WISC-R, CPT, WRAT, etc.).



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9. How would you describe your child's learning and problem-solving compared to other children of the same age?



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Mood & Anxiety Concerns

1. What concerns do you have about your child's emotions or moods?

2. Some children with ASD appear overly **anxious**. Which of the following are *significant* concerns at the present time?

Yes	No	
		Unrealistic worry about future events
		Worries excessively about schoolwork
		Blames self for things that are not his fault
		Worries excessively about how he does at sports
		Worries excessively about bad world events
		Worries excessively about upcoming events
		Worries excessively about getting sick or dying
		Very self-conscious or needs excessive reassurance
		Frequent complaints of body aches and pains
		Very scared to meet new people or social situations
		Frequent nightmares

When did these concerns begin? Specify age:

Please describe YES answers above:

Other comments:



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3. Some children with ASD appear **depressed or** experience emotional and behavioral challenges that can affect daily life. Please let us know if any of the following are concerns at this time.

Yes	No	
		Sad or irritable most of the day, nearly every day
		Diminished pleasure in activities that he/she used to like
		Change in appetite, or unexplained weight gain or loss
		Trouble falling asleep
		Excessively sleeping nearly every day
		Fatigue or loss of energy
		Agitated, on edge
		Feelings of worthlessness or excessive guilt
		Trouble concentrating, more forgetful than usual
		Suicidal thoughts or attempts

When did these concerns begin? Specify age:

Please describe YES answers above:

Other comments:



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4. Some children with ASD experience noticeable **compulsions or tics**. Which of the following are *significant* concerns at the present time?

Yes	No	
		Unusual rituals, obsessions (recurrent thoughts, feelings, ideas, or sensations that your child cannot get out of his/her mind) and/or compulsions (recurrent behaviors/actions such as counting, checking, twirling, etc.)?
		Fears of becoming aggressive toward others
		Religious obsessions
		Obsession with germs, diseases, or hygiene
		Obsessions about being on time or being late
		Obsessions about following rules
		Excessive hand washing
		Checking locks, ovens, etc.
		Arranging objects in certain ways
		Obsessively counting objects
		Saying repetitive words to self
		Motor tics (eg., blinking, squinting, facial jerking, shoulder shrugging)
		Vocal tics (eg., sniffing, clearing throat, habit cough, humming, noises)
		Biting lips or chewing on nails

When did these concerns begin? Specify age:

Please describe YES answers above:

Other comments:



Social Interaction

1. What concerns do you have about your child's social interactions with other children?

2. Please describe how your child gets along with siblings?

3. Does your child primarily play with children:

own age? _____ older? _____ younger? _____

Yes	No	Does your child...
		Respond to positive rewards?
		Understand or use body language to express him/herself?
		Engage in imaginary play?
		Have abnormal or unusual reactions to objects touching him/her?
		Exhibit extreme reluctance to take care of his/her personal hygiene?
		Have friends with whom he/she plays regularly?
		Talk to people who are not there?
		Believe he/she is someone else?
		Believes he/she hears voices talking to him/her?
		See things that are not there?



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Social History

1. Is your current spouse/significant other the child's biological parent

2. How would you describe your family household functioning (circle all that apply)?

Warm	Friendly	Loving	Caring	Stress-free
Chaotic	In crisis	Unstable	Stressful	Supportive
Other:				

3. Please list all people living in the child's household, and their relationship to the child:

Person's name	Age	Relationship to the child

4. Parent/ Caregiver 1 job/place of employment _____

Parent/ Caregiver 2 job/place of employment: _____

Parent/ Caregiver 1 highest education level: _____

Parent/ Caregiver 2 highest education level: _____



6. Types of discipline you use with your child:

Yes	No	
		Verbal reprimands or corrections
		Time out (isolation)
		Loss of privileges
		Rewards for positive behavior
		Ignoring negative behavior
		Physical punishment (eg., spanking)
		Give in to child
		Avoidance of child

7. Have any of the following stressful events occurred within the past 2 years?

Yes	No	
		Parents divorced or separated
		Change in primary caretaker
		Caretaker has new live-in significant other
		Family accident or illness
		Death in the family
		Parents changed or lost job
		Changed schools
		Family moved
		Family financial problems
		Severe psychological trauma (specify):
		Other (please specify):



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8. Does your child comply with *initial* commands?

Most of the time

Some of the time

Almost never

9. Does your child *eventually* comply with commands?

Most of the time

Some of the time

Almost never

10. What are your child's main hobbies and interests?

11. What does your child enjoy doing most?

12. What does your child dislike doing most?

13. What are your child's areas of greatest accomplishment?



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14. How many hours a day does your child spend:

On the computer: _____

Watching TV: _____

Playing video games: _____

Reading: _____

Playing outdoors: _____



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Developmental Screen

Pregnancy

1. Mom's age when child was born: _____ Duration of pregnancy (weeks): _____

2. Any health problems or infections with mom during pregnancy? If so, specify: _____

3. Medications taken by mother during pregnancy:

4. Smoking by mother during pregnancy? _____ if so, how many packs per day? _____

5. Drug use by mother during pregnancy? _____ If so, which drugs? _____

Alcohol use during pregnancy? _____ If so, how much/what kind _____

Drug use by father at time of conception? _____ If so, which drugs? _____

Delivery/Nursery Course

1. Type of labor (circle): spontaneous or induced

2. Type of delivery (check):

- Normal/vaginal
- breech
- caesarian/c-section

3. Birth weight _____

4. Complications during delivery or afterwards?



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5. Did your newborn require oxygen for more than 4 hours after delivery? _____
6. As an infant, did your child have jaundice? _____ Did he/she require phototherapy? _____
7. As an infant, did your child have an infection? _____
8. Number of days was hospitalized after delivery: _____
9. Any health complications in your newborn after birth?

Infancy/Toddler Period

Yes	No	Infancy
		Were there feeding problems during early infancy (0-4 months of age)?
		Was the baby difficult to cuddle?
		Was the baby colicky or more fussy than usual?
		Were there sleep pattern problems during early infancy?
		Were there problems with the infant's alertness?
		Did the baby have any congenital problems?
		Would you say your baby was difficult (did not calm easily or follow a schedule, excessive crying)?
		Was the baby excessively restless?
Toddler		
		Did the toddler behave poorly with others?
		Did the toddler throw excessive temper tantrums?
		Was the toddler insistent and demanding?
		Was the toddler extremely active, into everything?
		Was the child accident prone or clumsy?



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Developmental Milestones

At what age did the child smile?	
At what age did the child roll over?	
At what age did the child sit up?	
At what age did the child crawl?	
At what age did the child walk?	
At what age did the speak single words (besides dada/mama)?	
At what age did the child string two or more words together?	
At what age did the child speak in sentences?	
At what age did the child achieve bladder control?	
At what age did the child learn to ride a tricycle?	
At what age did the child ride a bicycle without training wheels?	
At what age did the child button clothing?	
At what age did the child tie shoelaces?	
At what age did the child name colors?	
At what age did the child say the alphabet?	
At what age did the child begin to read?	



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Medical History

Concerns

1. Rate your child on the following:

Good	Average	Poor	
			General health
			Hearing
			Vision
			Walking
			Running
			Throwing
			Catching
			Shoelace tying
			Buttoning
			Handwriting
			Athletic ability

2. Has your child had any chronic health problems (e.g., asthma, heart condition, diabetes, etc.)? If so, please specify (include overnight hospitalizations):

3. When was the onset of any chronic illness?



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4. Has your child had any of the following illnesses:

Yes	No	
		Mumps
		Chicken pox
		Measles
		Whooping cough
		Scarlet fever
		Pneumonia
		Encephalitis (brain infection)
		Meningitis
		Ear infections
		Lead poisoning
		Seizures (convulsions)

5. Has your child experienced any of the following:

Yes	No	
		Heart murmur
		Heart rhythm problem (arrhythmia)
		Heart surgery
		Unexplained chest pain with exercise
		Shortness of breath with exercise
		Unexplained inability to keep up with other kids during exercise
		Unexplained racing heart for no reason
		Palpitations (skipping heart beats) for no reason
		Sudden collapse for no reason
		Fainting or loss of consciousness



6. Has your child had any accidents resulting in the following:

Yes	No	
		Broken bones
		Severe lacerations
		Head injury, coma, amnesia
		Severe bruises
		Stomach pumped (poisoning)
		Eye injury
		Sutures (stitches)

7. Is there any suspicion of alcohol or drug use by the child or adolescent? _____
8. Is there any history of trauma? _____
9. Does your child have any problems sleeping? YES/NO
10. Is there a TV in your child's bedroom? YES / NO
11. Does the child sleep by himself? YES / NO
12. What is your child's bedtime? _____
13. When does the child actually fall asleep? _____
14. What time does your child wake on school days? _____ On weekends? _____
15. Does your child snore? YES / NO does your child's sleep restless? YES / NO
16. Does your child have any problems with bed-wetting or having bowel movements in his/her pants _____
17. Does your child have any symptoms of disordered eating _____



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Treatment History

1. List names and addresses of all other professionals who have seen your child for these concerns:

Professional	Phone number

2. Have you tried any of the following interventions for your child’s behavior (please describe)?

Dietary changes: _____ Supplements/Vitamins: _____

Natural remedies:

3. Has your child ever received any of the following medications for ASD:

Yes	Duration	Good effects observed?	Side effects or problems?	Medication
				Methylphenidate/Ritalin
				Concerta
				Focalin
				Dextroamphetamine/Dexedrine
				Adderall/Adderall XR
				Antidepressants
				Mood stabilizers
				Anticonvulsants
				Other:



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4. Has your child ever received any of the following forms of psychological treatment?

Yes	No	Duration	
			Individual psychotherapy or counseling
			Group psychotherapy or counseling
			Family therapy with child
			Inpatient evaluation and treatment
			Residential treatment (including drug and alcohol)



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Family History

Father's Family History

Please check whether anyone on father's side of the family has had the following problems:

Relationship to Child	Father	Paternal G.mother	Paternal G.father	Paternal Aunts	Paternal Uncles
Problems with aggression, defiance, and oppositional behavior as a child					
Problems with attention, hyperactivity, and impulse control as a child					
Learning disabilities or poor school performance					
Failed to graduate from high school					
Mental retardation					
Autism or Pervasive Developmental Disorder					
Psychosis or schizophrenia					
Hospitalization in a psychiatric or mental hospital					
Depression greater than 2 weeks					
Anxiety disorder					
Obsessive Compulsive Disorder					
Bipolar or Manic-Depressive Disorder					
Tics or Tourette's Syndrome					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests or jail time					
Perpetrator of physical abuse					
Perpetrator of sexual abuse					
Victim of physical abuse					
Victim of sexual abuse					
Heart rhythm problems/arrhythmias					
Sudden death due to heart problem under age 50					
Congenital heart disease					

Please describe any YES answers above (e.g., what diagnoses or treatments were given):



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Mother's Family History

Please check whether anyone on mother's side of the family has had the following problems:

Relationship to Child	Mother	Maternal G.mother	Maternal G.father	Maternal Aunts	Maternal Uncles
Problems with aggression, defiance, and oppositional behavior as a child					
Problems with attention, hyperactivity, and impulse control as a child					
Learning disabilities or poor school performance					
Failed to graduate from high school					
Mental retardation					
Autism or Pervasive Developmental Disorder					
Psychosis or schizophrenia					
Hospitalization in a psychiatric or mental hospital					
Depression greater than 2 weeks					
Anxiety disorder					
Obsessive Compulsive Disorder					
Bipolar or Manic-Depressive Disorder					
Tics or Tourette's Syndrome					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests or jail time					
Perpetrator of physical abuse					
Perpetrator of sexual abuse					
Victim of physical abuse					
Victim of sexual abuse					
Heart rhythm problems/arrhythmias					
Sudden death due to heart problem under age 50					
Congenital heart disease					

Please describe any YES answers above (e.g., what diagnoses or treatments were given):



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Siblings Family History

Please check whether any of your child's siblings has had the following problems:

Relationship to Child	Brother	Brother	Sister	Sister	
Problems with aggression, defiance, and oppositional behavior as a child					
Problems with attention, hyperactivity, and impulse control as a child					
Learning disabilities or poor school performance					
Failed to graduate from high school					
Mental retardation					
Autism or Pervasive Developmental Disorder					
Psychosis or schizophrenia					
Hospitalization in a psychiatric or mental hospital					
Depression greater than 2 weeks					
Anxiety disorder					
Obsessive Compulsive Disorder					
Bipolar or Manic-Depressive Disorder					
Tics or Tourette's Syndrome					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests or jail time					
Perpetrator of physical abuse					
Perpetrator of sexual abuse					
Victim of physical abuse					
Victim of sexual abuse					
Heart rhythm problems/arrhythmias					
Sudden death due to heart problem under age 50					
Congenital heart disease					

Please describe any YES answers above (e.g., what diagnoses or treatments were given):



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Current Medications & Natural Remedies

Please list any medications (over the counter or prescribed) or herbal/natural remedies your child is *currently* taking:

Some children have difficulties with eye contact. Which of the following have been/are significant problems?

Y/N Making eye contact with adults

Y/N Making eye contact with peers

Y/N Making eye contact during the first year of life

Please describe yes answers above:

Some children have difficulties with social interaction. Which of the following are significant problems?

Y/N Enjoying socializing with other children

Y/N Seeking out other children to play

Y/N Playing cooperatively with other children

Please describe yes answers above:



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Some children have repetitive behaviors, like hand flapping, running in a specific circle, twirling, or spinning. Have you noticed repetitive behaviors in your child?

Some children have unusual preoccupations, such as a specific interest in a toy, TV show, book, or character. Have you noticed any unusual preoccupations in your child?

Some children have unusual sensory sensitivities, such as to noises, lights, or textures of clothing or food. Have you noticed any sensory sensitivities in your child?



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Some children have unusual sensory interests, such as smelling things, touching things, or watching spinning things. Have you noticed any unusual sensory interests in your child?

Some children have a desire for structure or a need for specific routines. Have you noticed a desire for structure or a need for specific routines in your child?

Has your child ever experienced or witnessed any emotional, physical, or sexual abuse or other trauma?



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Thank you!

Please return these papers and other SMART Forms to:

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