UAMS Health | James L. Dennis Developmental Center

PACKET 1

Dear Parent/Guardian,

We recently received a referral from your child's primary care physician requesting an appointment at our clinic, the James L. Dennis Development Center (DDC). This Parent Intake Packet (Packet #1) includes a Parent Intake Form and a Release of Information Form. To schedule your child's appointment, please complete and sign the Parent Intake Form and the Release of Information forms and return them to us. It is important to provide up-to-date contact information, so we can successfully communicate with your regarding your child's appointment.

Once we receive your completed forms, here's what you can expect:

- We will notify you to let you know the status of your child's appointment. Depending on the type and availability of the appointment needed to help your child, your child may be scheduled for an appointment at the DDC, scheduled for an appointment at a different clinic, or placed on a waitlist until an appointment is available.

- Our services are specialized, and we receive an extraordinary number of referrals. Families often wait several months for an appointment.

- We must have your active insurance on file to schedule your child. If you have an insurance change, are a self-pay patient, or lose your insurance, please contact us immediately at 501-364-1830 so we can assist you so there is no delay in scheduling your child's appointment.

- Our Family Navigator can assist you:
    - Help find services (educational, therapy, and early interventions).
    - Provide resources (financial, advocacy, legal).
    - Help enroll in MyChart and field related questions.
    - Explain what to expect at the appointment.
    - Offer follow up support after the appointment.

  The Family Navigator can be reached by email, ddcfamilynavigator@uams.edu or by calling 501-364-1179.

Ways to Return Completed Forms

Completed forms may be returned to the James L. Dennis Developmental Center any of the following ways:

Fax	Email	Mailed or Delivered
501-364-4931	ddcfrontdesk@uams.edu	1301 Wolfe Street Little Rock, AR 72202

Visit Us Online at UAMSHealth.com

Find more information, go to UAMSHealth.com, click on the Locations tab and search for James L. Dennis Developmental Center.

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PACKET 1

REQUIRED PARENT INTAKE FORM FOR NEW PATIENTS TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name:	Today's Date:
Child's Social Security #:	Child's Race:
Child's Date of Birth:	Sex: ☐ Male ☐ Female
Name of Person Completing this Form:	
Email address:	
Your Relation to the Child:	
Child's Address with City/State/Zip Code & County:	
Parent/Guardian Name(s):	Home Phone Number: Cell Phone Number:
What is the PRIMARY language spoken in the home?	
Will parent(s) need an interpreter? ☐ Yes ☐ No	Will the patient need an interpreter? ☐ Yes ☐ No

What are your main concerns about your child's development, learning and/or behavior?

____

____

____

How old was your child when you became concerned? ______________________

Please tell us what you hope to get from your child's appointment at our clinic:

____

____

____

Does your child go to school or day care? ☐ Yes ☐ No Name of school/preschool: ________________

Has your child ever been evaluated for special education services, developmental delays or learning problems? ☐ Yes ☐ No Date(s) of most recent evaluation: ______________________

Has your child EVER had any of the following tests or evaluations?

Hearing	☐ Yes ☐ No	___ Passed ___ Failed
Vision	☐ Yes ☐ No	___ Passed ___ Failed
Speech-Language Evaluation	☐ Yes ☐ No	Currently gets this therapy ☐ Yes ☐ No
Occupational Therapy Evaluation	☐ Yes ☐ No	Currently gets this therapy ☐ Yes ☐ No
Physical Therapy Evaluation	☐ Yes ☐ No	Currently gets this therapy ☐ Yes ☐ No

What has your child's teacher shared with you about your child? (Positive or negative)

____

____

Please list any current **medications** your child is taking for **sleep, behavior, mood or attention:** _______

____

____

Please list any chronic or recurrent medical conditions your child has (*Asthma, Cerebral Palsy, Seizures, Genetic Disorders, Cardiac Issues, etc…*):

____

____

Please list any previous developmental, behavioral or psychiatric diagnoses given to your child (*this includes diagnoses such as Speech-Language Delay, Autism, ADHD, Bipolar, Anxiety, etc…):*

____

____

Please check "yes" or "no" for each of the following questions and explain, as needed:

Does your child…	***(check)***	***(explain)***
Prefer to play alone?	o Yes o No	
Respond to his/her name?	o Yes o No	
Have unusual body movements (hand-flapping, toe-walking, etc.)?	o Yes o No	
Have poor eye contact?	o Yes o No	
Have any unusual fixations or obsessions?	o Yes o No	
See or hear things that are not there?	o Yes o No	
Frequently repeat other people or TV/movies?	o Yes o No	
Hit, slap, bite, pinch or injure themselves in any other way?	o Yes o No	
Make serious threats of self-harm?	o Yes o No	
Make serious threats to harm others?	o Yes o No	
Seem overly hyperactive or impulsive?	o Yes o No	
Have unusually aggressive behavior towards others?	o Yes o No	
Have a lot of trouble paying attention/focusing?	o Yes o No	
Currently under the treatment of a psychiatrist or counselor?	o Yes o No	

List any other information you feel might be helpful in determining the best type of evaluation or services for your child:

____

____

*****IMPORTANT TO READ*****

A scheduling decision or appointment will not be made until we receive this completed form and confirm you have active insurance. If you have trouble completing this form, please ask your child's PCP, teacher/therapist, case worker or other(s) for assistance. Please include copies of reports from any past evaluations (speech, physical, speech therapies, school, etc.) with this form, if you have them.

____ _______________________

Signature of Parent/Legal Guardian Date

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

Authorization for Release of Information TO UAMS

1. I,____, hereby authorize:
   Name/Facility ____
   Complete Address ____
   Street Address *City* *State* *Zip*
   Phone ____________________ Fax ____________________

2. To release to: **UAMS Medical Center**
   Dennis Development Center
   1301 Wolfe Street
   Little Rock, AR 72202
   Phone (501) 364-1830
   Fax (501) 526-5422

3. Information of:
   Patient name____________________ Medical Record # (if known) ____________________
   Birthdate____ Phone ____________________

4. Information is to be limited to the following Dates of Treatment (if applicable):____________________

5. Information requested to be released:_______ Development Evaluations ______ Speech Evaluations
   _______ Occupational Evaluations _________ Physical Therapy Evaluations ____________ Other

6. Purpose of release is at the request of the patient or: __________Medical Care ___________ Other

7. This authorization will expire 90 days from the date on which it was signed unless I specify a different time period. Expiration Date or Event:_______________ I understand that I may revoke this authorization at any time by giving written notice. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

8. I understand that once the above info rm at ion is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by federal privacy laws and regulations.

9. Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

Signature of Patient
or Legal Representative____ Date/Tim e ___________________________

If Legal Representative, authority of Legal Representative ____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

Provide a copy to Patient/Legal Representative