

## **Patient Intake Packet**

Welcome to the UAMS Dennis Developmental Center (DDC)! To better understand your child's needs and give them the best care possible, we need some information from you.

### **How to schedule a visit and complete forms**

This form will be used to determine what type of appointment your child will have. Once an appointment slot is available, we will call you to schedule your child's visit. To complete this packet:

**1. Fill out all forms including:**

- Patient and Guardian Information Form
- Child Development Intake Form
- Medical History Form

**If you need help, you can:**

- Call a Family Navigator at 501-364-1830.
- Ask your child's doctor, teacher, therapist, or case worker for help.

**2. Email or fax your completed packet to:**

DDC  
Email: [ddcfrontdesk@uams.edu](mailto:ddcfrontdesk@uams.edu)  
Fax: 501-364-4931

### **How to pay for your child's visit**

How much you will pay for your child's visit depends on whether or not you have insurance.

- **If you have insurance:** You will pay your part of the cost (copay) on the visit day.
- **If you do not have insurance:** We will see if you qualify for insurance or assistance.
  - If you qualify, you will pay your part of the cost on the day of your child's visit.
  - If you do not qualify, you will pay the full cost of the visit when you make your child's appointment. Our staff member will explain the costs to you.

### **What to bring if you are not the biological parent**

If you are not your child's biological parent, you must provide legal proof that you have the right to make medical decisions for them. Proof can include:

- Guardianship papers
- Custody agreements
- Court orders

If you have someone other than a legal guardian bringing your child:

- **Complete a Permission to Share** form with this person's name included.
- **Note:** UAMS does not allow non-legal guardians to access patient records. Visit reports will only be sent to the legal guardian listed in our system.

## **Patient and Guardian Information Form**

This form helps us gather important information about your child and their parent(s) or legal guardian(s). Complete this form by selecting the box or filling in the blanks with the requested information. If a section does not apply, write "N/A" (Not Applicable).

### **Child (Patient) Information**

<b>Full name:</b> _____	<b>Name they go by:</b> _____
<b>Date of birth:</b> _____	<b>Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Race</b> (Check one):	<b>Language spoken in child's home:</b>
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> English
<input type="checkbox"/> Asian	<input type="checkbox"/> Spanish
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Marshallese
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Other: _____
<input type="checkbox"/> White	<b>Do you need an interpreter for the visit?</b>
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes. Language: _____
<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> No

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP Code:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Doctor's name:** \_\_\_\_\_ **Doctor's number:** \_\_\_\_\_

**Name of person completing this form:** \_\_\_\_\_

**Relationship to child:** \_\_\_\_\_

### **Child's Parent or Guardian (1) Information**

**Full name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Relationship to child:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

By giving your email, you agree to get health information by email. You can opt out at any time.

**Address:**  Same as child's address.  Different address (fill in below)

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP Code:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Employer and job title:** \_\_\_\_\_

**Highest grade finished in school:** \_\_\_\_\_

## Child's Parent or Guardian (2) Information

Full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

By giving your email, you agree to get health information by email. You can opt out at any time.

Address:  Same as child's address.  Different address (fill in below)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ County: \_\_\_\_\_

Employer and job title: \_\_\_\_\_

Highest grade finished in school: \_\_\_\_\_

## Insurance Information

List all insurance plans your child has, including Medicaid, PASSE, and private insurance.

### Medicaid or TEFRA Insurance:

Policy Number: \_\_\_\_\_ Check if you have:  Medicaid A  Medicaid B

### PASSE Insurance:

Name of PASSE: \_\_\_\_\_ PASSE policy number: \_\_\_\_\_

### Private Insurance:

Company: \_\_\_\_\_ Insurance phone number: \_\_\_\_\_

Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Policy holder's date of birth: \_\_\_\_\_ Policy holder's phone number: \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Is the policy holder's address the same as the child's?  Yes  No (If no, list below)

Address: \_\_\_\_\_

## Guarantor Information

The "Guarantor" is the person who is responsible for paying for the child's care.

Same as patient's guardian

Different from patient's guardian. If you check this box, list the information below.

Full name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Phone number: \_\_\_\_\_ Other number: \_\_\_\_\_

Email: \_\_\_\_\_

By giving your email, you agree to get health information by email. You can opt out at any time.

Is the guarantor's address the same as the child's?  Yes  No (If no, list below)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ County: \_\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

## Child Development Intake Form

Fill out this form to help us better understand your child's development. Your answers will help us to give the best care and support to your child.

Check the main concerns that you want to talk about at your child's visit?

- |  |  |
|--|--|
| <input type="checkbox"/> Social Skills<br><input type="checkbox"/> Play Skills<br><input type="checkbox"/> Sensory processing<br><input type="checkbox"/> Speech/communication delays<br><input type="checkbox"/> Other Developmental delays<br><input type="checkbox"/> Focus and activity level<br><input type="checkbox"/> Mood and anxiety | <input type="checkbox"/> Behavior (aggression, breaks rules)<br><input type="checkbox"/> Feeding difficulties (restricted diet)<br><input type="checkbox"/> Learning (in Math/ Reading/ Writing)<br><input type="checkbox"/> Thinking, memory and understanding<br><input type="checkbox"/> Change in thinking or problem-solving<br><input type="checkbox"/> Other concerns (toileting, self-care difficulties or others) |
|--|--|

Please give any details about the concerns checked above: \_\_\_\_\_

Have others such as child's doctor, teacher or therapist talked to you about getting your child evaluated for a certain diagnosis? If yes, please provide details: \_\_\_\_\_

Has your child been evaluated before? *If yes, check all that apply and fill in the information. If you have copies of testing, please bring them to your appointment.*

EVALUATION	DATE / LOCATION	DIAGNOSIS (IF ANY)
<input type="checkbox"/> Autism		
<input type="checkbox"/> Behavior issues (such as ADHD/ ODD)		
<input type="checkbox"/> Evaluation for developmental, speech, occupational or physical therapy		
<input type="checkbox"/> IQ or Psychoeducational testing		
<input type="checkbox"/> Neuropsychological testing		
<input type="checkbox"/> Mental health or Psychiatry		

### Child's Developmental and Behavioral History

Answer each section and give details when needed in the space provided.

If the question does not apply to your child, write "N/A" (meaning "Not Applicable").

#### **Your child's development milestones**

When did your child start doing the following activities? *If they have not done an activity yet, write "not yet."*

MILESTONE	AGE	MILESTONE	AGE
Walk alone		Say first words	
Completely potty trained		Use 2- to 3-word phrases	
Put on their own clothes		Speak in full sentences	

Has your child lost any skills they used to have, such as talking or walking?  No  Yes  
 If yes, please provide details: \_\_\_\_\_

Check all boxes that apply and give details about your checked answers in the spaces provided if needed.

**Motor skills:**

- No concerns
- Trouble with walking/moving
- Clumsiness/tripping often
- Trouble using hands

**Self-care skills:**

- No concerns
- Needing help with daily tasks (such as toileting, dressing)

**Speech and communication**

**How does your child usually tell you what they want/need?**

- Reaches for things with an open hand
- Pulls your hand to lead you to what they want
- Uses your hand to do something (for example: open or activate something)
- Cries or grunts to communicate
- Makes sounds instead of words
- Gestures (like nods head, shrugs shoulder)
- Sign language
- Uses a communication device
- Uses a single finger point
- Single words
- Short phrases
- Full sentences

**Does your child have or do the following:**

- No trouble with speech or language
- Trouble expressing themselves with words
- Trouble understanding what others say
- Difficulty pronouncing words
- Babble or use made up sounds instead of words (jargons)
- Make odd noises, repetitive sounds
- Say certain words or phrases over and over
- Repeat or mimic what others say
- Trouble reading other people’s facial expressions or body language
- Takes things literally
- Talk mostly about their own topics of interest or have trouble maintaining a back and forth conversation
- Trouble understanding jokes, sarcasm, or slang
- Often speaks in a very direct or blunt way to others
- Use an unusual tone or volume of voice when speaking (such as sounding robotic or singsong or uses loud tone or high pitch)
- Have a poor understanding of social situations

Provide details if needed: \_\_\_\_\_

**Social skills**

**Does your child:**

- Have no trouble with social skills
- Rarely play or respond when other kids try to talk or play with them
- Rarely approaches other kids to play
- Not often look when you point out something interesting
- Fail to point out things of their interest to you

- Rarely bring you things to show or share, like toys or objects they find interesting
- Avoid or struggle with making or keeping eye contact
- Have trouble showing different facial expressions in response to people or situations
- Prefer to play alone

- Struggle to make or keep friends or not seem interested in making friends
- Act bossy or insist on strict rules during play
- Get bullied or teased by other children
- Overly social with strangers or not have “stranger danger”
- Not aware of others’ personal space

Provide details if needed: \_\_\_\_\_

### Play and interests

What does your child like to play with? \_\_\_\_\_

#### Does your child:

- Have no trouble with play skills
- Struggle with playing pretend
- Have little interest in toys for kids their age
- Tend to get repetitive in play (such as lining up, spinning, or arranging toys)
- Have unusual interests or collection of things
- Seem overly focused on certain toys or topics
- Get upset with change or stopping one activity and starting another
- Need to do things the same way every time or insist on set routines

Provide details if needed: \_\_\_\_\_

### Sensory behaviors and motor mannerisms

Does your child show any of the following sensory differences or mannerisms?

<i><b>CHECK ALL THAT APPLY</b></i>	<b>PLEASE DESCRIBE</b>
<input type="checkbox"/> <b>Have strong likes or dislikes about touch</b> (such as prefer certain textures of clothing, avoiding touch, or wanting tight hugs)	
<input type="checkbox"/> <b>Have trouble with sounds</b> (such as covering their ears for certain sounds or not responding to their name when called)	
<input type="checkbox"/> <b>Avoid certain foods or brushing teeth or often put things in their mouth that are not food</b> (such as chewing on toys, shirts)	
<input type="checkbox"/> <b>Look at objects in unusual ways</b> (such as very closely, from the side of their eye, or from odd angles)	
<input type="checkbox"/> <b>Smell objects often</b>	
<input type="checkbox"/> <b>Find ways to move</b> (such as climbing, jumping off things, spinning, crashing into things)	
<input type="checkbox"/> <b>Not seem to feel pain</b> (like scrapes or bruises)	
<input type="checkbox"/> <b>Other sensory differences</b>	

<input type="checkbox"/> <b>Move their bodies in a repeated way</b> (such as flapping hands, rocking their body back and forth, walking on their toes, or tensing their body)	
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### **Mood, temperament, and behavior**

#### **Does your child have or do the following:**

- Frequent mood changes (such as sudden sadness, crying, or being easily upset or angry)
- Seem anxious or worry a lot
- Have extreme tantrums or meltdowns
- Show aggression toward others or objects
- Show aggression toward themselves
- Argue often with adults, refuse to follow rules, or not show remorse for wrongdoing

- Struggle with paying attention or staying focused
- Often act without thinking (impulsive)
- Constantly moving, always "on the go" (hyperactive)
- Not seem to be aware of danger
- Wander off, run away, or try to escape from adults
- People have difficulty managing child's emotions/behavior at home or school? If yes, who is having trouble? \_\_\_\_\_

Provide details if needed: \_\_\_\_\_

### **Eating & Nutrition**

#### **Does your child have or do the following:**

- Poor appetite
- Trouble with chewing or swallowing (such as choking or gagging on food or drinks)
- Putting too much food in their mouth at once (overstuffing)
- Struggle with eating using spoon or fork or drinking from a cup
- Prefer eating with their hands

- Tend to overeat
- Eat only a few specific foods
- Being very particular about food or mealtimes (such as the brand of food or how it's cooked or presented)
- Dislike of certain food textures (such as avoiding crunchy/ mushy/mixed foods)
- Taking or hiding food (such as stealing or hoarding food)

Provide details if needed: \_\_\_\_\_

### **Sleep**

Does your child have a bedtime routine?  No  Yes

#### **Does your child have or do the following:**

- Struggle with falling asleep
- Struggle with staying asleep (such as waking up in the night or too early)
- Refuse bedtime (such as making excuses to stay up or get out of bed)
- Having nightmares or night terrors
- Talking or walking in their sleep
- Restless sleep

- Snoring or breathing through their mouth at night
- Watching TV or using screens within an hour of bedtime
- Need medicines to help with sleep. If yes, list med: \_\_\_\_\_
- Had a previous sleep study? If yes, provide details here: \_\_\_\_\_

## Medical History Form

### Pregnancy and Birth History

Check 'yes' or 'no' to questions about birth mother and baby's birth. Give details in the blanks provided if needed. If you do not know or recall some details, share what you can.

PREGNANCY		PROBLEMS DURING PREGNANCY
Mother's age at time of delivery:		<i>Check all that apply:</i> <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Anemia (low iron in blood) <input type="checkbox"/> Preeclampsia (high blood pressure and protein in urine) <input type="checkbox"/> Required bedrest <input type="checkbox"/> Placenta previa <input type="checkbox"/> Mental health concerns <input type="checkbox"/> Experienced any other complications/medical issues. Provide detail if needed for selected answers above: _____ _____
Received prenatal care:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Experience physical trauma/injury:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Exposed to x-rays, toxins, chemicals:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Took prescription medication: If yes, please list: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Used illicit substances/drugs during pregnancy If yes, please list which drugs: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Smoked cigarettes during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Used alcohol during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	

DELIVERY		PROBLEMS DURING/AFTER DELIVERY
Length of pregnancy in weeks:		<i>Check all that apply:</i> <input type="checkbox"/> Baby's heart rate dropped <input type="checkbox"/> Born "blue" and could not breathe on their own at birth <input type="checkbox"/> Low Apgar score <input type="checkbox"/> Cord was around baby's neck <input type="checkbox"/> Breech (baby did not come headfirst) <input type="checkbox"/> Meconium (baby passed their first stool before they were born) <input type="checkbox"/> Neurological concerns (affecting brain/nerve) <input type="checkbox"/> Jaundice (baby had high bilirubin) <input type="checkbox"/> Other complications/medical problems from delivery until the first few months of life. Please list: _____ _____ Baby passed newborn hearing screen? <input type="checkbox"/> No <input type="checkbox"/> Yes
Place of baby's birth (city or hospital):		
Baby's weight at birth:	____ lb ____ oz	
Was labor induced by doctors?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
How was the baby delivered:	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section	
Forceps/vacuum used to get baby out?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Did baby go to intensive care (NICU) or was the baby transferred to a different hospital:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure	
Length of baby's stay at hospital before going home:		

## Child's Medical history and Review of Body Systems

Check any past or current health problems your child has & provide age when it happened:

PROBLEM OR CONDITION	AGE	PROBLEM OR CONDITION	AGE
<input type="checkbox"/> Growth problems (height/weight)		<input type="checkbox"/> Constipation	
<input type="checkbox"/> Genetic condition		<input type="checkbox"/> Reflux	
<input type="checkbox"/> Head Injury or trauma		<input type="checkbox"/> Kidney disease	
<input type="checkbox"/> Seizures or staring spells		<input type="checkbox"/> Problems with urination/bedwetting	
<input type="checkbox"/> Headache		<input type="checkbox"/> Bone /joint / muscle issues	
<input type="checkbox"/> Hydrocephalus or shunt		<input type="checkbox"/> Anemia ("low iron")	
<input type="checkbox"/> Meningitis		<input type="checkbox"/> Other blood conditions (sickle cell)	
<input type="checkbox"/> Movement disorder, tics, or Tourette		<input type="checkbox"/> Birthmarks	
<input type="checkbox"/> Eye or vision problem		<input type="checkbox"/> Other skin conditions (such as eczema)	
<input type="checkbox"/> Ear (ear infections) or hearing issue		<input type="checkbox"/> Diabetes or hypoglycemia	
<input type="checkbox"/> Cleft lip or palate		<input type="checkbox"/> Thyroid conditions	
<input type="checkbox"/> Dental Problems		<input type="checkbox"/> Allergies (food, medication, seasonal) List here: _____	
<input type="checkbox"/> Nose/throat condition (strep throat)		<input type="checkbox"/> Previous hospitalizations	
<input type="checkbox"/> Dysphagia (swallowing problems)		<input type="checkbox"/> Other serious illnesses	
<input type="checkbox"/> Asthma or respiratory issues		Surgeries <input type="checkbox"/> Dental <input type="checkbox"/> Circumcision <input type="checkbox"/> Ear Tubes <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Tongue tie repair	
<input type="checkbox"/> Heart defects /heart rhythm issues			
<input type="checkbox"/> Fainting spells		<input type="checkbox"/> Other medical problems, list here: _____	
<input type="checkbox"/> Frequent falls or injury			

If you selected concerns above, provide detail here if needed: \_\_\_\_\_

Has the child been seen by other doctors (such as Genetics, Neurology, Rehabilitation Medicine, Gastrointestinal specialists etc.)? If yes, list them here: \_\_\_\_\_

### Medical Tests

Check the box if your child has had any of these tests. Provide details of date, location and result of test if this is known

TEST	WHERE AND WHEN WAS TEST?	RESULT, IF YOU KNOW
<input type="checkbox"/> EEG (measures brain activity)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> MRI (magnetic scan of the body)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> CT scan (X-ray imaging test)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> Swallow study (tests swallowing)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> Audiology (hearing evaluation)		<input type="checkbox"/> Passed <input type="checkbox"/> Failed

<input type="checkbox"/> If your child wears hearing aids: <input type="checkbox"/> Left ear <input type="checkbox"/> Right ear <input type="checkbox"/> Both ears		<input type="checkbox"/> Passed with hearing aids <input type="checkbox"/> Failed with hearing aids
<input type="checkbox"/> Vision test or screening		<input type="checkbox"/> Passed <input type="checkbox"/> Failed
<input type="checkbox"/> If your child wears glasses:		<input type="checkbox"/> Passed with glasses <input type="checkbox"/> Failed with glasses
<input type="checkbox"/> Other tests (example: Genetics test)		

## Medicines

Write down the medicines your child is taking, the dose (amount taken each time), and the reason your child is taking it. Check whether child is taking medicine now or in the past

NAME OF MEDICINE	DOSE	REASON FOR TAKING	CURRENTLY TAKING	TOOK IN THE PAST
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

## Family Medical History

Check the health conditions that apply in your child's family and write how the person is related to the child (e.g. aunt). Note if the relative is on the mother's side (maternal) or father's side (paternal).

HEALTH DIAGNOSIS	HOW IS PERSON RELATED TO CHILD
<input type="checkbox"/> Autism Spectrum Disorder	
<input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD)	
<input type="checkbox"/> Speech delay	
<input type="checkbox"/> Intellectual Disability	
<input type="checkbox"/> Learning Disability (in Math, Reading or Writing)	
<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Bipolar	
<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Drug addiction	
<input type="checkbox"/> Alcohol addiction	
<input type="checkbox"/> Genetic Disorder/syndrome (list here: _____)	
<input type="checkbox"/> Cerebral palsy	
<input type="checkbox"/> Seizures/Epilepsy	
<input type="checkbox"/> Other Nerve/Brain conditions such as migraine, stroke, tics)	
<input type="checkbox"/> Vision loss/impairment	

<input type="checkbox"/> Hearing loss/impairment	
<input type="checkbox"/> Heart defect or heart rhythm conditions	
<input type="checkbox"/> Early death or sudden unexplained death (less than age 55)	
<input type="checkbox"/> Endocrine or Hormone conditions	
<input type="checkbox"/> Other conditions (example: cancer, etc.)	

## Social history

Check what applies to your child's family, home life, and any changes or challenges they may be facing.

What is the child's birth parents' marital status?

Single    Married    Divorced    Widowed    Separated    Other: \_\_\_\_\_

If the parents are divorced, when did the divorce happen? \_\_\_\_\_

Is there a legal custody arrangement between parents?    No    Yes

Has one of the child's parents passed away?    No    Yes

If yes, tell us who and when: \_\_\_\_\_

Is the child adopted?    No    Yes - at what age? \_\_\_\_\_

Does the child know they are adopted?    No    Yes

Does your child live in more than one household?    No    Yes

If yes, explain how your child divides their time between homes: \_\_\_\_\_

Write everyone who currently lives in your child's home. If your child lives in more than one place, list the people in each place:

NAME	AGE	RELATIONSHIP TO CHILD

Are there any problems that may be bothering your child right now? (Example, a recent death, family move, divorce or separation, or other changes): \_\_\_\_\_

## Therapies/ treatment

Check the boxes for any therapies your child is receiving now or in the past. Give details of location or provider giving the therapy. Check "Yes" or "No" to show if your child is currently receiving treatment. If your child is not currently receiving treatment, list the dates or ages when they last received it.

THERAPY/TREATMENT	LOCATION WHERE THERAPY IS DONE OR NAME OF THERAPY PROVIDER	GETTING THERAPY NOW?	WHEN DID YOUR CHILD LAST GET THIS IF NOT NOW?
<input type="checkbox"/> Speech Therapy		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Developmental Therapy		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Applied Behavioral Analysis (ABA)		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Counseling or Behavioral Therapy		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Psychiatry / counseling services		<input type="checkbox"/> No <input type="checkbox"/> Yes	

### School history

Tell us about your child's current and past school experiences.

Is child attending school or daycare?  No  Yes

If yes, fill in the blanks or check the boxes that apply:

Name of current daycare/school:	
Current grade or level:	
Name of previous daycare or school/s attended, if any:	
Has your child repeated a grade?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes: which grade? _____
Does your child have an:	<input type="checkbox"/> Individualized Education Plan (IEP) <input type="checkbox"/> 504 Plan
What kind of classroom does your child learn in? Check all that apply <input type="checkbox"/> General education <input type="checkbox"/> Virtual <input type="checkbox"/> Home school <input type="checkbox"/> Resource classes for academic support (such as Reading, Writing, Math) <input type="checkbox"/> Alternative learning environment (ALE) <input type="checkbox"/> Therapeutic day treatment (TDT) <input type="checkbox"/> Self-contained/CBI (Community-based instruction) special education <input type="checkbox"/> Inclusion services for special education	

Are you satisfied with your child's current school placement and services?  No  Yes

(Please explain) \_\_\_\_\_

### What else should we know?

Use this space for any other details you think will help us understand your child better or evaluate their needs: \_\_\_\_\_

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Date: \_\_\_\_\_  
Age 0-13

## Attention and Behavior Rating Form, Home Version: Child (English)

Child's name: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Completed by: Mother \_\_\_ Father \_\_\_ Guardian \_\_\_ Grandparent \_\_\_

Please select the answer that *best describes your child's behavior over the past 6 months.*

How often does your child display this behavior?	Never or Rarely	Sometimes	Often	Very Often
Fails to give close attention to details or makes careless mistakes in schoolwork or during other activities	0	1	2	3
Has difficulty sustaining attention in tasks or play activities	0	1	2	3
Does not seem to listen when spoken to directly	0	1	2	3
Does not follow through on instructions and fails to finish schoolwork or chores	0	1	2	3
Has difficulty organizing tasks and activities	0	1	2	3
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework)	0	1	2	3
Loses things necessary for tasks or activities (e.g., school materials, pencils, books, eyeglasses)	0	1	2	3
Easily distracted	0	1	2	3
Forgetful in daily activities (e.g., doing chores)	0	1	2	3

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How much do the nine behaviors in the previous question cause problems for your child:	No Problem	Minor Problem	Moderate Problem	Severe Problem
Getting along with family members	0	1	2	3
Getting along with other children	0	1	2	3
Completing or returning homework	0	1	2	3
Performing academically in school	0	1	2	3
Controlling behavior in school	0	1	2	3
Feeling good about himself/herself	0	1	2	3

**Please continue on back**

**Attention and Behavior Rating Form, Home Version: Child (English) (page 2 of 2)**

<b>How often does your child display this behavior?</b>	<u>Never or Rarely</u>	<u>Sometimes</u>	<u>Often</u>	<u>Very Often</u>
Fidgets with or taps hands or feet or squirms in seat	0	1	2	3
Leaves seat in situations when remaining seated is expected	0	1	2	3
Runs about or climbs in situations where it is inappropriate	0	1	2	3
Unable to play or engage in leisure activities quietly	0	1	2	3
"On the go," acts as if "driven by a motor"	0	1	2	3
Talks excessively	0	1	2	3
Blurts out an answer before a question has been completed	0	1	2	3
Has difficulty waiting his or her turn (e.g., while waiting in line).	0	1	2	3
Interrupts or intrudes on others	0	1	2	3

Adapted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Copyright © 2013. American Psychiatric Association. All rights reserved.

<b>How much do the nine behaviors in the previous question cause problems for your child:</b>	<u>No Problem</u>	<u>Minor Problem</u>	<u>Moderate Problem</u>	<u>Severe Problem</u>
Getting along with family members	0	1	2	3
Getting along with other children	0	1	2	3
Completing or returning homework	0	1	2	3
Performing academically in school	0	1	2	3
Controlling behavior in school	0	1	2	3
Feeling good about him-/herself	0	1	2	3

From *ADHD Rating Scale-5 for Children and Adolescents: Checklists, Norms, and Clinical Interpretation* by George J. DuPaul, Thomas J. Power, Arthur D. Anastopoulos, and Robert Reid. Copyright © 2016 the authors. Permission to photocopy this form is granted to purchasers of this book for personal use or use with individual clients (see copyright page for details).

(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



## **NOTICE OF PRIVACY PRACTICES**

*Effective Date: April 8, 2013*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**This Notice is provided on behalf of the University of Arkansas for Medical Sciences including its Medical Center Research Institute, and clinics, Psychiatric Research Institute, Area Health Education Centers, and other facilities ("UAMS"). UAMS provides patient care through a healthcare system committed to education and research.**

**PURPOSE:** This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify the patient and that relates to the patient's past, present or future physical or mental health, and may include name, address, phone numbers and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, with required revisions, if any, may be obtained from the UAMS web site, <http://www.uamshealth.com/> and will be posted in prominent areas of our facilities. You may also receive a current copy by sending a written request to the UAMS HIPAA Office, 4301 W. Markham #829, Little Rock, AR 72205.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive at UAMS Medical Center and its clinics, Area Health Education Centers and other UAMS facilities. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your Privacy Rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services. To file a complaint with us, you may send a letter describing the violation to the UAMS HIPAA Officer, 4301 W. Markham #829, Little Rock, AR 72205. There will be no retaliation for filing a complaint.

If you have questions or need more information, contact the UAMS HIPAA Office at 501-614-2187.

**WHO WILL FOLLOW THIS NOTICE:** This Notice describes the practices of UAMS healthcare professionals, employees, volunteers and others who work or provide healthcare services at any UAMS facility, including students-in-training.

**ACKNOWLEDGMENT:** You will be asked to sign an Acknowledgment of receipt of this Notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this Acknowledgment.

**Your Privacy Rights.** You have the following rights relating to your Protected Health Information. You may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of your records, in paper or electronic form. You may be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional identified by UAMS who was not involved in the original denial decision. We will comply with the outcome of this review.
- Request that we amend your record, if you feel the information is incomplete or incorrect. We are allowed to deny this request in certain circumstances and may ask you to put these requests in writing and provide a reason that supports your request.
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to the requested restrictions, unless you are requesting to restrict certain information from your health plan and have paid for your UAMS services in full.
- Obtain a record of certain disclosures of your Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- Provide us with written permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.
- Submit any written requests to inspect, copy or amend your records to the UAMS Health Information Management Department.

(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



## **NOTICE OF PRIVACY PRACTICES**

**Our Responsibilities.** We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, and make the Notice available to you. We are also required to notify you if a breach of your health information occurs.

### **Examples of Uses & Disclosures**

**We will use your Protected Health Information for treatment.** Certain information obtained by a nurse, doctor, therapist, or other healthcare worker will be put into your record and used to plan and manage your treatment. We may provide reports or other information to your doctor or other authorized persons who are involved in your care, including healthcare providers outside of UAMS. We may make your protected health information available electronically through an electronic health information exchange to other health care providers and health care providers and health plans that request your information for their treatment and payment purposes. Participating in an electronic health information exchange may also let us see their information about you for our treatment and payment purposes.

**We will use your Protected Health Information for payment.** A bill will be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used. We may also disclose limited information about your bill to others, such as collection agency, to obtain payment.

**We will use your Protected Health Information for regular healthcare operations.** UAMS may use your Protected Health Information to check on the care you received, how you responded to it, and for other business purposes related to operating the hospital or clinics. UAMS is a teaching facility, and information about you may be shared with students and trainees for teaching purposes.

**Business Associates:** We may share some of your Protected Health Information with outside people or companies who provide services for us, such as typing physician reports.

**Patient Directory:** Unless you tell us not to, we may disclose your name, location in the facility, and general condition to people who ask for you by name. If provided by you, your religious affiliation may also be given to members of the clergy.

**Notification:** We may use or disclose your Protected Health Information with a family member or other person involved in your care, your location and general condition unless you tell us not to do so.

**Communication with family:** We may share your Protected Health Information with a family member, a close personal friend, or a person that you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.

**Research:** Your Protected Health Information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

**Coroners, Medical Examiners, Funeral Directors:** In the event of your death, we may disclose your Protected Health Information to these people, to the extent allowed by law, so that they may carry out their duties.

**Organ Donor Organizations:** We may share your Protected Health Information with the organ donation agency for the purpose of tissue or organ donation in certain circumstances and as required by law.

**Contacts:** We may contact you to provide appointment reminders or to tell you about new treatments or services.

**Fundraising and Marketing:** We may contact you as part of UAMS fundraising or marketing efforts. You have a right to opt out of Fundraising communications and may do so by calling 1-888-995-UAMS (8267) or emailing advancement@uams.edu.

**Food and Drug Administration:** We may share your Protected Health Information with certain government agencies like the FDA so they can recall drugs or equipment.

**Workers Compensation:** We may disclose your Protected Health Information for workers' compensation claims.

**Public Health:** We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and as required by law.

**Communicable Disease:** We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.

(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



### **NOTICE OF PRIVACY PRACTICES**

**Correctional Institution:** If you are an inmate of a correctional institution, we may disclose your Protected Health Information to the institution or law enforcement as needed for your health or the health and safety of others.

**Law Enforcement:** We must disclose your Protected Health Information for law enforcement purposes as required by law.

**As Required by Law:** We must disclose your Protected Health Information when required by federal, state or local law, such as to report gunshot wounds.

**Health Oversight:** We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.

**Abuse or Neglect:** We must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect involving children or endangered adults.

**Legal Proceedings:** We must disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process, as allowed by law.

**Required Uses and Disclosures:** We must make disclosures when required by Secretary of Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

**To Avoid Harm:** We may use and disclose information about you when necessary to prevent a serious threat to your health or safety of the health or safety of the public or another person.

**For Specific Government Functions:** In certain situations, we may disclose Protected Health Information of military personnel and veterans. We may disclose your Protected Health Information for national security activities required by law.

**Sale of Information:** UAMS will not sell your information without your prior written authorization or as otherwise allowed by law.



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MR#:

Patient's Name:

Patient's Address:



## ***Acknowledgment of Receipt of Privacy Notice***

By signing this form, you are only agreeing that you have received a copy of the UAMS Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Print Legal Representative's Name (if applicable)

\_\_\_\_\_  
Legal Representative's Signature

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

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### **STAFF USE ONLY**

We provided the Notice of Privacy Practices and attempted to obtain written acknowledgment but acknowledgment could not be obtained because:

Patient or Legal Representative declined to sign the Acknowledgment of Receipt.

Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Printed Name of Employee Completing Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of Employee Completing Form

\_\_\_\_\_  
UAMS Location



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(Place MR Label Here)

MRN#:

Patient's Name:

Patient's Address:



### Authorization for Release of Information TO UAMS

1. I, \_\_\_\_\_, hereby authorize:
  1. Preschool and Complete Address/Phone \_\_\_\_\_
  2. School District and Complete Address/Phone \_\_\_\_\_
  3. Therapy Provider and Complete Address/Phone \_\_\_\_\_
  4. Local Mental Health Provider and Complete Address/Phone \_\_\_\_\_

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 Number (if known) \_\_\_\_\_

Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

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

5. Most Recent Evaluations requested to be released: \_\_\_\_\_ Developmental \_\_\_\_\_ Speech \_\_\_\_\_ Occupational \_\_\_\_\_ Physical \_\_\_\_\_ Psychoeducational/Psychological \_\_\_\_\_ IEP/504 \_\_\_\_\_

6. The purpose of release is at the request of the patient for: \_\_\_\_\_ Medical Care \_\_\_\_\_ Other \_\_\_\_\_

7. This authorization will expire 90 days from the date on which this is signed unless there is a specified different date. 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 information 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/Time \_\_\_\_\_

**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 in healthcare proxy.

**Provide a copy to Patient/Legal Representative**

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Med Rec 99 TO (03/16)

Authorization for ROI

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(Place MR Label Here)  
MR#:  
Patient's Name:  
Patient's Date of Birth:



### Permission to Share Information with Family or Friends Involved in Your Care

We respect the privacy of your health information. If you wish to grant permission for us to share your medical or billing information with a family member or friend involved in your care, who is not otherwise authorized by law to act on your behalf, please specify below. You are not required to grant this permission and may revoke this permission at any time by contacting the UAMS HIPAA Office at 501-603-1379.

I give my permission to UAMS to share the health information of

\_\_\_\_\_ \_\_\_\_\_  
Print Patient Name Print Date of Birth

with the following person or persons:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient or Legal Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Name: \_\_\_\_\_

If Legal Representative, authority of Legal Representative: \_\_\_\_\_  
(such as parent of a minor, guardian, attorney-in-fact appointed with power of attorney, or healthcare proxy)



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## **Get Your Medical Information with MyChart**

UAMS Health MyChart is a free online portal where you can access your health information. You can:

- Ask for prescription medicine refills
- See your lab and test results
- Make an appointment with your doctor
- Send a message to your doctor
- View and pay your bill

### **How do I sign up for MyChart to see my records?**

Follow these steps to sign up for MyChart:

1. Ask your doctor, nurse, or clinic staff to send you a sign-up link by email or text.
2. Open the link within 8 hours and enter your name and date of birth to sign up.
3. If the link does not work, ask for a new one.

To access the MyChart page or get information about the MyChart App for your phone, go to **<https://UAMShealth.com/MyChart>**

**Sign up for MyChart today!**