



DOERNBECHER
CHILDREN'S
Hospital

Welcome to the Child Development and Rehabilitation Center and the OHSU Doernbecher Children's Hospital

We are honored that you chose us to care for your child. Our goal is to provide the highest quality care in a timely and respectful manner.

On the following page, we have provided you with a list of items you will need to obtain to help us with your child's evaluation.

We need you to return all the required documents before we can place your child on a waiting list for an appointment. Please either mail, fax or email the documents to our office as soon as possible to:

Oregon Health & Science University
Attention: CDRC
PO Box 574
Portland OR 97207-0574
Fax: 503 494-4447
email: cdrcnorthunit@ohsu.edu

If you have any questions or problems completing these forms, or need this information in another language, please call 877-346-0640.

Please use black ink on all forms, make a copy of anything you send in the mail, and always keep your originals.

Thank you for your time and effort in completing and returning the packet. We look forward to working with you and your family.

If you need this information in another language, please call 877-346-0640.



DOERNBECHER
CHILDREN'S
Hospital

Frequently Asked Questions about CDRC Evaluations

When should I call to check on the status of my child's referral?

CDRC receives many referrals each week and we strive to connect you with OHSU's registration department within 48 hrs. If you do not hear from us within 5 business days, please call 503-346-0640.

When do I receive an intake packet?

Please call 503-494-5252 to update your child's registration information, as this step is required (even if you have previously worked with CDRC). Please have your insurance card available when you call. After contacting registration, your intake packet should arrive within 10 business days.

How long are your clinical program's waitlists?

We have several different evaluation clinics at CDRC. Patients are assigned to a particular clinic depending on their age, symptoms, diagnoses (if known), and information from your returned intake packet. Each clinic's wait time is different, and you may have to wait several months after you have returned the packet for an appointment.

When should I call to check where my child is on their clinical program's waitlist?

You can call to check if your returned intake paperwork has been received by our clinic (please make copies of everything you send by mail), and should also call to let us know if anything has changed, such as your address or phone number. However, please wait 90 days before calling to check where your child is on the waitlist, as it often takes that long to process the information.

Will my insurance cover this cost?

We work with most insurance plans, but each policy is different. We recommend that you contact your insurance company early to make sure our services are covered, that we are in your network, and that any needed authorizations are taken care of in advance. Testing for learning disabilities, if needed, is usually not covered by medical insurance, and can be done by your school district.

Can I bring other children to the appointment?

Your attendance in clinic is required during the entire appointment (which may last from 1 ½ hours to 6 hours in length). Please have additional siblings and family members stay at home from this appointment.

How do I fill out the Authorization to Use and Disclose Protected Health Information?

Please see the next page for a sample form.



Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence

901 E. 18th Avenue
Eugene, OR 97403-9900
(541) 346-3575, Fax (541) 346-5844

Page 1 of 1

Write in the information of the
hospital, school/teacher, agency,
or individual that you are
requesting send your child's
records to CDRC

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: _____
(Name of person / entity/ facility disclosing information)

(Address of person / entity) (City) (State) (Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check
here ☒ for a paper copy. This release is regarding:

Write your Child's first and last name

Check any
records you are
requesting be
sent to CDRC

(Name of individual)
consisting of: (see back side for definitions) ☒ Physician reports ☒ X-rays (please see the back side of this form for
complete instructions) ☒ Labs ☐ ED ☐ Billing
☒ Other, specify Medical records, psychological records, or Educational records
☐ If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) (see back side for
practice/clinic list) _____

to: Child Development and Rehabilitation Center (CDRC Eugene)
(Name of recipient)
901 E. 18th Avenue Eugene OR 97403
(Address of recipient) (City) (State) (Zip Code)

for the purpose of: (Describe each purpose of disclosure) ☐ Continued Care ☐ Legal ☐ Disability
☐ School Entry ☒ Other, specify medical evaluation

If the information to be disclosed contains any of the types of records or information listed below, additional laws
relating to the use and disclosure of the information may apply. I understand and agree that this information will be
disclosed only if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Genetic testing information
_____ Mental health information _____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health
care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health
services is if the health services are solely for the purpose of your enrollment in a health plan. You are eligible to enroll in the
health plan. You may revoke this authorization in writing at any time. Your revocation of this authorization will not affect any
disclosures already made.

Sign your initials if there is any
information being requested that
pertains to psychiatry, psychology,
mental health evaluations or testing
that you want sent to CDRC

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A,
OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure
and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-
disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis,
treatment or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) _____

By: _____ Date: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____

ONLINE 6/12 (Supersedes 5/04)

MR-1470

Sign, Date, and write in your Legal Authority
(mother, father, guardian, foster parent, etc.)



Oregon Health & Science University
Hospitals and Clinics
Child Development and Rehabilitation Center
P.O. Box 574
Portland, OR 97207-0574
(503) 494-8095, Fax (503) 494-4447

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

Page 1 of 1

Patient Identification

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: _____
(Name of person / entity/ facility disclosing information)

(Address of person / entity)

(City)

(State)

(Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check here ☐ for a paper copy. This release is regarding:

(Name of individual)

consisting of: (see back side for definitions) _____ Physician reports _____ X-rays _____ Labs _____ ED
_____ Billing _____ CDRC Reports _____ Other, specify _____

_____ If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) (see back side for practice/clinic list) _____

to: _____
(Name of recipient)

(Address of recipient)

(City)

(State)

(Zip Code)

for the purpose of: (Describe each purpose of disclosure) _____ Continued Care _____ Legal _____ Disability
_____ School Entry _____ Other, specify _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information

_____ Genetic testing information

_____ Mental health information

_____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) _____

By: _____ Date: _____ Time: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____





**Oregon Health & Science University
Hospitals and Clinics
Child Development and Rehabilitation
Center**
P.O. Box 574
Portland, OR 97207-0574
(503) 494-8095, Fax (503) 494-4447

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Continued from page 1

Patient Identification

DEFINITION OF REPORTS:

- Physician reports include Discharge Summary, Discharge instructions, History & Physical exam, any procedures or operations
- X-rays include X-ray reports, Ultra sound, MRI, and special Imaging reports (**If you are requesting for an actual image please make sure to fill out the Authorization Form MR-4775**) The form may be accessed at the following web site: <http://ozone.ohsu.edu/healthsystem/HIS/mr4775.pdf>
- Labs – all laboratory test results
- ED – Emergency Department reports by physician
- Billing – Hospital and / or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed

OHSU OUTPATIENT PRACTICES/CLINICS:

Adult Psychiatry
Allergy & Immunology
Anticoagulation
Audiology
Bone & Mineral
Bone Marrow Transplant / Leukemia
Cardiology
Casey Eye Institute
CDRC Eugene
Center for Women's Health
Child and Adolescent Psychiatry
Childhood Development and Rehabilitation
(CDRC)
Comprehensive Pain Center
Dermatology
Dermatology Surgery
Diabetes
Digestive Health
Doernbecher Pediatrics - Westside
Employee Health
Endocrinology
Executive Health
Family Medicine at South Waterfront
Gabriel Park
Gastroenterology
General Pediatrics
General Surgery
GI / Hepatology
Health Promotion and Sports Medicine
Hematology / Oncology

Infectious Disease
Intercultural Psychiatry Program
Internal Medicine
Knight Cancer Center/Community Hematology
Oncology
Lipids
Liver Transplant
Marquam Hill Internists
Nephrology & Hypertension
Neurology
Neurosurgery
Oral & Maxillofacial Surgery
Orthopaedics
Otolaryngology
Pediatric Hematology / Oncology
Pediatric Specialties
Perinatal
Plastic Surgery
Pulmonary
Radiation Oncology
Renal Transplant
Rheumatology
Richmond
Riverplace
Scappoose
Sleep Medicine
Surgical Oncology
Urology
Vascular Surgery



CHILD DEVELOPMENT AND REHABILITATION CENTER

Intake Packet

The following items are needed from you before we can place you on the wait list for an appointment. If you have any questions or problems completing these forms, or need this information in another language, please call 503-346-0640.

Please make a copy of anything you send in the mail, and always keep originals. Please complete all forms in BLACK ink.

Items for you to complete:

- ☐ OHSU Child Development and Rehabilitation Center, Patient Medical History
- ☐ NICHQ Vanderbilt Assessment Scale, Parent Informant
- ☐ Call patient registration at 503-494-8505 to set up or update your child's account with OHSU. Please have insurance information ready when you call.

Items to obtain from school:

A Release of Information form is enclosed if you would like the school to send this information to us directly.

- ☐ Teacher Questionnaire
 - ☐ NICHQ Vanderbilt Assessment Scale, Teacher Informant
- These are to be completed by a teacher, therapist, daycare provider, or home visitor.*

If your child has an Individualized Education Plan (IEP) or 504 Plan, also include:

- ☐ Copy of Individualized Education Plan (IEP) or 504 Plan paperwork (if available)
- ☐ Copy of most recent testing or special education eligibility testing (if available)

Other Information (optional):

- ☐ Consider including copies of any prior testing related to learning, language, sensory/motor skills, or behavior AND/OR recent progress notes from current intervention/therapy providers

You may send packet by mail to:

Oregon Health & Science University
Attention: CDRC
PO Box 574
Portland, OR 97207-0574

You may also email or fax documents to:

Fax: 503-494-4447
email: cdrcnorthunit@ohsu.edu



Patient name: _____

Date of birth: _____

Patient label here

Please fill out this form as fully as you can. Use more paper if needed.

Your name: _____ Date: _____

Relationship to child: _____ Who is child's legal guardian? _____

What name does your child like to be called? _____

If other languages spoken at home, which does the child understand most? _____

Speak the most? _____

☐ Check if child is adopted and list birth country: _____ age at adoption: _____

1. What are you most concerned about?
2. When did these concerns begin?
3. What tests or treatments has your child had for these concerns?
4. What has been tried (including medicines) to help?
5. What does your child enjoy doing?
6. What would you like to see happen as a result of this visit?
7. Where do you feel like you could use the most help?

Current medications, diet, other health care needs

List all medications (from the doctor, over-the-counter, vitamins and supplements) that your child is taking now.
(Use more paper if needed)

Has child had vision tested in the past year: ☐ Yes ☐ No Results: ☐ Passed ☐ Failed

Has child had hearing tested in the past year: ☐ Yes ☐ No Results: ☐ Passed ☐ Failed

Immunizations up-to-date? ☐ Yes ☐ No ☐ Don't know

Allergies (Please list): ☐ Medications ☐ Foods ☐ Other ☐ None known



Patient name: _____

Date of birth: _____

Patient label here

Pregnancy and birth history

Birth parent's age at baby's birth: _____

How many times has birth parent been pregnant? _____

Which pregnancy is this child? _____

Any miscarriages or terminated pregnancies?

☐ Yes ☐ No ☐ Don't know

☐ How many? _____

☐ Child is in foster care or adopted and perinatal history is limited

During pregnancy did the birth parent have:	Yes	No
Diabetes		
High blood pressure		
Water broke more than 24 hours before delivery		
Birth parent used prescription medications: (explain)		
Birth parent smoked cigarettes (explain)		
Birth parent drank alcohol (explain)		
Birth parent used recreational/street drugs: (explain)		
Birth parent experienced significant stress, emotional trauma, physical trauma		
Other serious illness / complications during pregnancy (explain):		

Delivery	Yes	No
Induced labor		
<input type="checkbox"/> Forceps used or <input type="checkbox"/> vacuum extraction		
Delivery by C-section		
Twins or multiple births		
<input type="checkbox"/> Baby was early; weeks premature: _____		
<input type="checkbox"/> Baby was late; weeks postmature: _____		
Birthweight: _____ Length: _____		
Other complications: (explain)		

After delivery baby had:	Yes	No
Serious breathing difficulty		
Infections		
Jaundice		
I.V. or tube feedings		
Seizures or convulsions		
Required a stay in Intensive Care Unit (NICU)		
Baby discharged home at _____ days old		
Other concerns: (explain)		



Patient name:

Date of birth:

Patient label here

Review of systems (all ages)

Eyes, ears, nose, mouth, throat	Yes	No
Vision or eye concerns		
Concerns with hearing		
Frequent ear infections		
Dental concerns		
Choking or gagging while feeding		
Other concerns (explain):		

Skin	Yes	No
Eczema or hives		
Other skin condition (explain):		
Birthmarks (explain):		

Cardio-respiratory (heart/lungs)	Yes	No
Asthma		
Chronic cough		
Pneumonia		
Heart murmur or congenital heart defect		
Other concerns (explain):		

Abdominal region (stomach/intestines)	Yes	No
Abdominal pain		
Poor appetite		
Picky eater		
Spells of vomiting		
Frequent constipation		
Frequent diarrhea		
Other concerns (explain):		

Genitals/urinary tract	Yes	No
Bed wetting		
Urinary tract or kidney infection		
Daytime urinary accidents		
For girls, has menstruation begun		
Other concerns: (explain):		



Patient name:

Date of birth:

Patient label here

Muscles and bone structure	Yes	No
Hip dysplasia or dislocation		
Foot or leg deformity		
Scoliosis or other back deformity		
Other concerns (explain):		

Nervous system	Yes	No
Frequent headaches		
Convulsions or seizures		
Staring spells		
Muscle tics, uncontrollable twitches		
Serious head injury or unconsciousness (explain):		
Other concerns (explain):		

Speech and language	Yes	No	Don't know
Delays in speech (sounds) / language (words)			
Do you or others have problems understanding your child?			
Are other languages spoken at home?			

Development	Age	Don't know
Rolled over		
Was able to sit without support		
Learned to crawl		
Walked independently		
Learned to ride tricycle		
Learned to ride bicycle		
Started to babble (sounds like "baba" or "dada")		
Played games like "peek a boo," "pat a cake"		
Pointed to indicate wants		
Used first words other than "mama" and "dada"		
Used 2-3 word phrases		
Used sentences		
Toilet trained during day		

Sleep	Yes	No	Don't know
Loud snoring			
Difficulty falling/staying asleep			
Other concerns: (explain):			



Patient name: _____

Date of birth: _____

Patient label here

Family history (please complete each field and list all members of your family or, if known, for foster or adopted child)

Biological mother's name: _____ Age: _____

Medical, mental health, or school/learning concerns? ☐ Yes ☐ No

Lives in child's home? ☐ Yes ☐ No

Biological father's name: _____ Age: _____

Medical, mental health, or school/learning concerns? ☐ Yes ☐ No

Lives in child's home? ☐ Yes ☐ No

Important family members:

Name: _____ Relationship to patient: _____ Age: _____

Lives in child's home? ☐ Yes ☐ No

Name: _____ Relationship to patient: _____ Age: _____

Lives in child's home? ☐ Yes ☐ No

Name: _____ Relationship to patient: _____ Age: _____

Lives in child's home? ☐ Yes ☐ No

Name: _____ Relationship to patient: _____ Age: _____

Lives in child's home? ☐ Yes ☐ No

Name: _____ Relationship to patient: _____ Age: _____

Lives in child's home? ☐ Yes ☐ No

Name: _____ Relationship to patient: _____ Age: _____

Lives in child's home? ☐ Yes ☐ No

Name: _____ Relationship to patient: _____ Age: _____

Lives in child's home? ☐ Yes ☐ No

Medical history of biological family: _____



Patient name:

Date of birth:

Patient label here

Social history

Serious illness or injury to child, caregiver, or sibling ☐ Yes ☐ No

Homelessness ☐ Yes ☐ No

Food insecurity ☐ Yes ☐ No

Family stress due to job loss or loss of income ☐ Yes ☐ No

Financial instability ☐ Yes ☐ No

Transportation instability ☐ Yes ☐ No

Would you be interested in connecting with resources that could help you with any of the items you checked above? _____

Events that happen in the family or home can sometimes have an effect on a person's behavior and learning.

☐ **Check here if you would rather answer this part of the form in person**

Please check if any of the following have been experienced by the patient:

- | | |
|---|--|
| <input type="checkbox"/> A parent has emotional or mental health illness | <input type="checkbox"/> Exposure to domestic/physical violence in the home |
| <input type="checkbox"/> Conflict between parents about parenting | <input type="checkbox"/> Death of parent or sibling |
| <input type="checkbox"/> Involvement with juvenile court or justice system | <input type="checkbox"/> Treatment by counselor, psychologist, or psychiatrist |
| <input type="checkbox"/> Involvement with social services/child protective services | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Custody disagreement | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Foster care placement | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Parent substance/alcohol abuse | <input type="checkbox"/> Parent separation or divorce |



Patient name: _____

Date of birth: _____

Patient label here

Child care and education

☐ Does your child go to daycare, school or preschool?

Name of the school/program: _____ Current grade: _____

Are they or have they been in an early intervention or special education program? ☐ Yes ☐ No

Does child receive any other supports?

☐ Individualized Education Plan (IEP) ☐ Individual Family Service Plan (IFSP) ☐ Title I supports ☐ 504 Plan

Please select any supports your child receives (if known). Please select all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Learning center / resource room | <input type="checkbox"/> Behavioral plan |
| <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Feeding plan or protocol |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Title I, 504 plan |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Mental health/counseling (why and how long?): _____ | |
| <input type="checkbox"/> Do you feel like your child needs extra help they are not getting at home or at school? _____ | |
| <input type="checkbox"/> Other (specify): _____ | |

Additional information

Is there anything else that is important for us to know about your child? Please add additional pages, if needed.

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past **6 months**.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil
Consumer & Specialty Pharmaceuticals

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:**For Office Use Only**

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy
of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil
 Consumer & Specialty Pharmaceuticals



DOERNBECHER
CHILDREN'S
Hospital

CHILD DEVELOPMENT AND REHABILITATION CENTER

Dear Teacher:

The parent(s)/guardian(s) of one of your students is seeking to have their child evaluated at the Child Development and Rehabilitation Center at Oregon Health & Science University. As part of the evaluation process, we are requesting the following information to assist us with the diagnosis and treatment of your student.

Please use black ink on all forms; make a copy of anything you send, and always keep your originals.

Items to complete:

- ☐ Teacher Vanderbilt Questionnaire (enclosed)
- ☐ Teacher Information Form (enclosed)

Items to provide to parent:

- ☐ Copy of Individualized Education Plan (IEP) or 504 Plan (if applicable)
- ☐ Copy of most recent special education eligibility testing (if applicable)

We ask that you complete the questionnaires and provide us with any other information as soon as possible as we are unable to begin the student's evaluation without it. Your time and cooperation in this matter are greatly appreciated.

You may give the completed questionnaires and other information directly to your student's parent or guardian for them to return to us. If the parent/guardian has signed a release of information, you may return the questionnaire directly to us at:

Oregon Health & Science University
Attention: CDRC
PO Box 574
Portland OR 97207-0574
Fax: 503-494-4447
email: cdrcnorthunit@ohsu.edu



**Institute on Development
and Disability (IDD)**

Child Development and
Rehabilitation Center

BRIEF TEACHER BEHAVIORAL QUESTIONNAIRE

Teacher's name: _____

School Name: _____

School Phone Number: _____

Today's Date: _____

tel 503-494-8312

877-346-0640

fax 503-494-4447

cdrcnorthunit@ohsu.edu

Mail code: CDRC

PO Box 574

Portland, OR 97207-0574

Child's Name: _____ Date of birth: _____

What are this student's biggest strengths as a student and classmate?

Do you have any concerns about the student's behavior? If yes, please briefly describe.

Does the student's behavior interfere with their academics? If yes, please briefly describe.

How does the student interact with his/her peers? (Does his/her behavior get in the way?)

Do you have any other concerns about the student?

What do you think this student needs to be successful in an educational environment?

Does the student receive any extra services at school? (i.e., IEP, 504 plan or other) If yes, please briefly describe.

Has the student had any previous testing done at school? If yes, please briefly summarize or provide copies of the results.

Please feel free to use additional sheets, if necessary.

Child's Name: _____ Date of Birth: _____

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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HE0351

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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