DOERNBECHER CHILDREN'S *Hospital*

OHSU

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*

OHSU

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

_____
(Name of individual)

Check any records you are requesting be sent to CDRC

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 (Address of recipient) | Eugene (City) | OR (State) | 97403 (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
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

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

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 ...e else, and the authorization is necessary to make that disclosure. You... ...t your enrollment in a health plan or eligibility for health benefits, unless ...u are eligible to enroll in the health plan.

You may revoke this authorization in writi... ...ation described above may no longer be used or disclosed for the pur... ...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: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____

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

MR1470

ONLINE 6/12 (Supersedes 5/04) **MR-1470**

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

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
_____ Mental health information
_____ Genetic testing 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:_____

MR1470

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

DOERNBECHER CHILDREN'S *Hospital*

OHSU

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 need help 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
- ☐ 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 daycare or preschool:

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

- ☐ Teacher Questionnaire
  This can be completed by a teacher, therapist, daycare provider, or other home visitor

If your child has an Individualized Family Service Plan (IFSP) also include:

- ☐ Copy of Individualized Family Service Plan (IFSP) (if available)
- ☐ Copy of most recent testing or special education eligibility testing (If available)

Other Information *(optional)*:

- ☐ Consider including copies of 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

DOERNBECHER CHILDREN'S *Hospital*

OHSU Child Development and Rehabilitation Center
Patient Medical History

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		
☐ Forceps used or ☐ vacuum extraction		
Delivery by C-section		
Twins or multiple births		
☐ Baby was early; weeks premature: _____ ☐ 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:

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

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

Additional information

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

DOERNBECHER CHILDREN'S *Hospital*

OHSU

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 Information Form (enclosed)

Items to provide to parent:

☐ Copy of Individualized Family Service Plan (IFSP) (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

Thank you for your assistance with the evaluation process.

Institute on Development and Disability (IDD)

Child Development and Rehabilitation Center

tel 503-494-8312
877-346-0640
fax 503-494-4447

cdrcnorthunit@ohsu.edu

Mail code: CDRC
PO Box 574
Portland, OR 97207-0574

BRIEF TEACHER BEHAVIORAL QUESTIONNAIRE

Teacher's name: _____

School Name: _____

School Phone Number: _____

Today's Date: _____

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:_____