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
e-mail: 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.*
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.
Write in the information of the hospital, school/teacher, agency, or individual that you are requesting send your child’s records to CDRC.

Check any records you are requesting be sent to CDRC.

Write your child’s first and last name.

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.

Sign, date, and write in your legal authority (mother, father, guardian, foster parent, etc.).
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:

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: ____________________________________________________________________________________________________________________________________________
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](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
- 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
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
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)
## Review of systems (all ages)

<table>
<thead>
<tr>
<th><strong>Eyes, ears, nose, mouth, throat</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision or eye concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns with hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent ear infections</td>
<td></td>
<td></td>
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<tr>
<td>Dental concerns</td>
<td></td>
<td></td>
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<tr>
<td>Choking or gagging while feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other concerns (explain):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Abdominal region (stomach/intestines)</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor appetite</td>
<td></td>
<td></td>
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<tr>
<td>Picky eater</td>
<td></td>
<td></td>
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<tr>
<td>Spells of vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent diarrhea</td>
<td></td>
<td></td>
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<tr>
<td>Other concerns (explain):</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Skin</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eczema or hives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other skin condition (explain):</td>
<td></td>
<td></td>
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<tr>
<td>Birthmarks (explain):</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cardio-respiratory (heart/lungs)</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart murmur or congenital heart defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other concerns (explain):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Genitals/urinary tract</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed wetting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary tract or kidney infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daytime urinary accidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For girls, has menstruation begun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other concerns: (explain):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Muscles and bone structure

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Other concerns (explain):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
- Hip dysplasia or dislocation
- Foot or leg deformity
- Scoliosis or other back deformity
- Other concerns (explain):   

### Nervous system

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Other concerns (explain):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>
- Frequent headaches
- Convulsions or seizures
- Staring spells
- Muscle tics, uncontrollable twitches
- Serious head injury or unconsciousness (explain):
- Other concerns (explain):  

### Speech and language

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>Other concerns (explain):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Delays in speech (sounds) / language (words)
- Do you or others have problems understanding your child?
- Are other languages spoken at home?

### Development

<table>
<thead>
<tr>
<th>Age</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- 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
- Toile trained during day

### Sleep

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Loud snoring
- Difficulty falling/staying asleep
- Other concerns: (explain):  

**Patient name:**

**Date of birth:**
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: ____________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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: 

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  ☐ Behavioral plan
☐ Speech therapy  ☐ Feeding plan or protocol
☐ Occupational therapy  ☐ Title I, 504 plan
☐ Physical therapy  ☐ 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.
## NICHQ Vanderbilt Assessment Scale—PARENT Informant

**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?

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

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.
<table>
<thead>
<tr>
<th>Symptoms (continued)</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
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<tbody>
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<td>33. Deliberately destroys others’ property</td>
<td>0</td>
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<td>2</td>
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<tr>
<td>34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)</td>
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<tr>
<td>35. Is physically cruel to animals</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36. Has deliberately set fires to cause damage</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>37. Has broken into someone else’s home, business, or car</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Has stayed out at night without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
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<td>39. Has run away from home overnight</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>40. Has forced someone into sexual activity</td>
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<td>41. Is fearful, anxious, or worried</td>
<td>0</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. Is afraid to try new things for fear of making mistakes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Feels worthless or inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. Blames self for problems, feels guilty</td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>45. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Is sad, unhappy, or depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. Is self-conscious or easily embarrassed</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<table>
<thead>
<tr>
<th>Performance</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. Overall school performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>49. Reading</td>
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<td>51. Mathematics</td>
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<td>2</td>
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<td>4</td>
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<tr>
<td>52. Relationship with parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>53. Relationship with siblings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>54. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>55. Participation in organized activities (eg, teams)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

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 2 or 3 in questions 48–55: _________________________
Average Performance Score: _________________________
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
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: __________________________
**NICHQ Vanderbilt Assessment Scale—TEACHER Informant**

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?

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

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.

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

National Initiative for Children's Healthcare Quality

McNeil

Consumer Specialty Pharmaceuticals

HE0351
Teacher’s Name: _______________________________  Class Time: ___________________  Class Name/Period: _______________

Today’s Date: ___________  Child’s Name: _______________________________ Grade Level: ______________________________

<table>
<thead>
<tr>
<th>Symptoms (continued)</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. Feels worthless or inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>33. Blames self for problems; feels guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>35. Is sad, unhappy, or depressed</td>
<td>0</td>
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<td>2</td>
<td>3</td>
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</table>

<table>
<thead>
<tr>
<th>Performance Academic Performance</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. Reading</td>
<td>1</td>
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<td>4</td>
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<tr>
<td>37. Mathematics</td>
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<td>2</td>
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<td>4</td>
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<tr>
<td>38. Written expression</td>
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<thead>
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<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>40. Following directions</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>41. Disrupting class</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>42. Assignment completion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>43. Organizational skills</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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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11-20/rev0303