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.
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

Write your Child’s first and last name

Check any records you are requesting be sent to CDRC

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)

(Name of individual)

(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: ______________________________________________________________

(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 (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 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
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

<table>
<thead>
<tr>
<th>During pregnancy did the birth parent have:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water broke more than 24 hours before delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth parent used prescription medications: (explain)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth parent smoked cigarettes (explain)</td>
<td></td>
<td></td>
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<tr>
<td>Birth parent drank alcohol (explain)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth parent used recreational/street drugs: (explain)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth parent experienced significant stress, emotional trauma, physical trauma</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Other serious illness / complications during pregnancy (explain): |    |

<table>
<thead>
<tr>
<th>Delivery</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induced labor</td>
<td></td>
<td></td>
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<tr>
<td>☐ Forceps used or ☐ vacuum extraction</td>
<td></td>
<td></td>
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<tr>
<td>Delivery by C-section</td>
<td></td>
<td></td>
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<tr>
<td>Twins or multiple births</td>
<td></td>
<td></td>
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<tr>
<td>☐ Baby was early; weeks premature: _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Baby was late; weeks postmature: _____</td>
<td></td>
<td></td>
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<tr>
<td>Birthweight: _________ Length: _________</td>
<td></td>
<td></td>
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<tr>
<td>Other complications: (explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After delivery baby had:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious breathing difficulty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.V. or tube feedings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures or convulsions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required a stay in Intensive Care Unit (NICU)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby discharged home at _____ days old</td>
<td></td>
<td></td>
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<tr>
<td>Other concerns: (explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Review of systems (all ages)

<table>
<thead>
<tr>
<th>Eyes, ears, nose, mouth, throat</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>
</tr>
<tr>
<td>Dental concerns</td>
<td></td>
<td></td>
</tr>
<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>Abdominal region (stomach/intestines)</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>
</tr>
<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>
</tr>
<tr>
<td>Other concerns (explain):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin</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>
</tr>
<tr>
<td>Birthmarks (explain):</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Genitals/urinary tract</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>

<table>
<thead>
<tr>
<th>Cardio-respiratory (heart/lungs)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
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<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>
<tr>
<td>Muscles and bone structure</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-----------------------------------</td>
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<tr>
<td>Hip dysplasia or dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot or leg deformity</td>
<td></td>
<td></td>
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<tr>
<td>Scoliosis or other back deformity</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>Nervous system</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions or seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staring spells</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle tics, uncontrollable twitches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious head injury or unconsciousness (explain):</td>
<td></td>
<td></td>
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<tr>
<td>Other concerns (explain):</td>
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</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Sleep</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loud snoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty falling/staying asleep</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>
**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

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.
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.
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: __________________________