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:

OHSU Health Information Management
3151 SW Sam Jackson Park Rd OP17A
Portland, OR 97239-9745

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 503-494-8505 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.

Child Development and Rehabilitation Center

Community Resources

What can we do now?
There are many resources in local communities for families in Oregon. You don't need to wait until you get your child's evaluation from Child Development and Rehabilitation Center (CDRC) to use these supports. You can start now!

If your child needs developmental support:
If you are worried about your child's progress, your Education Service District may be able to assist your family. They may offer testing or learning ideas. These methods review your child's thinking and learning, self-care, communication, sensory system and/or motor skills.

Children ages 0-5:

Babies and toddlers
Find help for children ages 0-5 through your county's Early Intervention (EI) or Early Childhood Special Education (ECSE) programs. Learn more at https://bit.ly/2XVGNSw.

Head Start programs
The Early Head Start program is for pregnant women, babies and toddlers. The Head Start program is for children ages 3-5. These programs help children get ready for school. They provide education, health and food services. There are also services for families of traveling or seasonal farmworkers. Learn more at www.ohsa.net.

If your child needs support at school:
If your child is in school, your child may be able to receive special education support from your school district. Contact your child's school to start the process. **You do not have to wait for the results of a CDRC evaluation to begin services with your school.**

For help with school-based services, contact:

FACT Oregon	1-888-988-3228	http://factoregon.org_or
Washington PAVE	253-565-2266	http://www.wapave.org
Stand for Children	800-663-4032	http://stand.org/oregon

If your family needs more than school services:
You can find support services through a community provider even if your child does not yet have an autism diagnosis.

Skill development and practice:
Ask your child's doctor for a therapy referral. Call your insurance carrier to learn which providers are covered near your home. Your insurance company's phone number will be on your insurance card.

- Speech-language pathologists work on communication skills, such as talking and listening, and social skills like playing together.
- Occupational therapists work on movement, daily living skills and sensory differences like reactions to noises and textures.

Behavioral and mental health support:
Families who have children with developmental differences may benefit from support of a mental health provider. These providers are skilled at helping families cope with challenging behaviors or other concerns, such as anxiety or ADHD. Your insurance carrier can help find a qualified provider. To find these services for mental health:

If you have private insurance:
Look for a telephone number on your insurance card.

If you have the Oregon Health Plan:
Call your local Coordinated Care Organization (CCO) to learn about these services. Find a list of CCOs at https://bit.ly/2D5E5lg.

If you have Washington State Medicaid:
Call your managed care plan. Find the list of managed care plans at https://bit.ly/2VBEITO.

Where else can we find help?

There are several support groups for families and children with developmental differences in Oregon. A few are:

- **The Oregon Center for Children & Youth with Special Health Needs (OCCYSHN)**
  www.occyshn.org or 503-494-8303

- **CaCOON Care**
  Coordination provided by home-visiting public-health nurses.
  http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm

- **FACT Family Support**
  www.factoregon.org or 1-888-988-3228

- **Oregon Family to Family**
  Provides information for families of children and youth with special health care needs.
  www.oregonfamilytofamily.org or 1-855-323-6744 (**Spanish:** 503-931-8930)

- **Autism Society of Oregon/Washington (ASO)**
  ASO can provide support and recommendations **regardless** of a child's medical diagnosis.
  https://autismsocietyoregon.org or 1-888-Autism-1 (1-888-288-4761)

Other ideas include:
- Local playgroups
- Local groups for parents of children with differences
- Local Parks and Recreation centers' classes for children who need more support

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:

OHSU Health Information Management
3151 SW Sam Jackson Park Rd OP17A
Portland, OR 97239-9745

You may also email or fax documents to:

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

CHILD DEVELOPMENT AND REHABILITATION CENTER PATIENT MEDICAL HISTORY

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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 the child had vision tested in the past year?

☐ Yes ☐ No Test Results: ☐ Passed ☐ Failed

Has child had hearing tested in the past year?

☐ Yes ☐ No Test Results: ☐ Passed ☐ Failed

Immunizations up-to-date?

☐ Yes ☐ No ☐ Don't know

Allergies (Please list):

☐ Medications ☐ Foods ☐ Other ☐ None known

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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 ☐ How many? _____

☐ No ☐ Don't know

☐ 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)		

	Yes	No
Birth parent drank alcohol (explain)		
Birth parent used recreational/street drugs: (explain)		
Birth parents experienced significant stress, emotional trauma, physical trauma		
Other serious illnesses/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 post mature _____		
Birthweight:_____ Length: _____		
Other complications: (explain)		

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Pregnancy and birth history (continued)

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)

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 conditions (explain):		
Birthmarks (explain):		

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

CHILD DEVELOPMENT AND REHABILITATION CENTER PATIENT MEDICAL HISTORY

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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
Bedwetting		
Urinary tract or kidney infection		
Daytime urinary accidents		
For girls, has menstruation begun		
Other concerns: (explain):		

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):		

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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

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		

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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:_____Language Relationship to patient:_____Age:_____

Lives in child's home? ☐ Yes ☐ No

Name:_____Language Relationship to patient:_____Age:_____

Lives in child's home? ☐ Yes ☐ No

Name:_____Language Relationship to patient:_____Age:_____

Lives in child's home? ☐ Yes ☐ No

Name:_____Language Relationship to patient:_____Age:_____

Lives in child's home? ☐ Yes ☐ No

Name:_____Language Relationship to patient:_____Age:_____

Lives in child's home? ☐ Yes ☐ No

Name:_____Language Relationship to patient:_____Age:_____

Lives in child's home? ☐ Yes ☐ No

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

- ☐ Death of parent or sibling
- ☐ Treatment by counselor, psychologist, or psychiatrist
- ☐ Neglect
- ☐. Physical abuse
- ☐. Sexual abuse
- ☐. Parent separation or divorce

Childcare and education

☐ Does your child go to daycare, school or preschool? ☐ Yes ☐ No

Name of the school/program:_____Current Grade:_____

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

Does the child receive any other support?

☐ 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:

OHSU Health Information Management
3151 SW Sam Jackson Park Rd OP17A
Portland, OR 97239-9745

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 503-346-0640
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:_____