UAMS Schmieding Developmental Center

PATIENT INFORMATION RE-EVALUATION PACKET

Please note, items marked by an "*" are used for statistical purposes only and will not affect your application.

PATIENT and GUARANTOR INFORMATION:

Child's Name_____ Birth Date_____

Age_____ *Sex_____ *Race_____ Primary Language_____ Social Security #_____

Medicaid Policy #_____ Insurance Co._____ Benefits Phone Number_____

Policy #_____ Group #_____

Subscriber_____ Relationship to Patient_____

Guarantor's Name_____ Relationship to Patient_____

(Person responsible for payment)

Social Security #_____ Birth Date_____ Employer_____

Home Phone #_____ Work Phone #_____ Cell Phone #_____ E-Mail_____

Guarantor's Address_____

P. O. Box or Street

_____

City State Zip Code County

Legal Guardian's Name _____ Relationship_____

Home Phone #_____ Work Phone #_____ Cell Phone #_____ E-Mail_____

Guardian's Address_____

P. O. Box or Street

_____

City State Zip Code County

EMERGENCY INFORMATION:

Nearest Relative_____ Relationship_____ Phone_____

Primary Physician_____ Phone_____

By providing your email address and signing below, you are agreeing that we may send medical related correspondence to you via email. You may withdraw your consent to email correspondence at any time by notifying a member of our office staff

Please fill out this form as completely as possible. This information is necessary to determine your child's accurate diagnosis and how best to serve your child needs.

Who referred you to this clinic?

Name_____ Relationship_____ Phone #_____

PARENT'S or CAREGIVER'S CONCERNS:

What are your current concerns? _____

_____

_____

What have you been told by doctors, teachers, and/or others about your child's problem? _____

_____

_____

What do you expect or hope to have happen as a result of an evaluation at the Schmieding Developmental Center?

_____

_____

CHILD'S DEVELOPMENTAL & MEDICAL HISTORY:

Medical:

Have there been any medical concerns or hospitalizations since your child's last evaluation at Schmieding? ☐ NO ☐ YES

If yes, then:

When? Why? Where? (name and city of hospital)

_____

_____

_____

_____

Does your child have any allergies (to medicines, foods, animals, etc.)? ☐ NO ☐ YES

If yes, to what and how does it affect him/her? _____

_____

List all medications your child currently takes or has taken for long periods of time in the past:

MEDICINE AMOUNT REASON WHEN TAKEN

_____

_____

_____

_____

_____

What medical tests (like x-rays, EEG, blood tests, etc.) has your child had done since your last appointment? ☐ NONE

What test? When done? What result?

_____

_____

_____

Sleep Habits:

Does your child have any problems with sleep? ☐ NO ☐ YES

If yes, explain: _____

_____

_____

Behavioral Habits:

Does your child have any behavioral problems? ☐ NO ☐ YES

If yes, explain: _____

_____

_____

FAMILY MEDICAL/DEVELOPMENTAL HISTORY:

Biological Father's Name _____ Date of Birth _____

First Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other Vocational Training _____

Gross Annual Income* _____ Home Phone #_____Cell # _____

Biological Mother's Name _____ Date of Birth _____

First Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other Vocational Training _____

Gross Annual Income* _____ Home Phone #_____Cell # _____

Is the child Adopted? ☐ NO ☐ YES If so please fill out the following information:

Age at Adoption_____ Is the child aware he/she is adopted? ☐ NO ☐ YES

Adoptive-Father/Guardian_____ Date of Birth _____
First Last
Occupation _____ Employer _____
Highest Grade Completed _____ Other Vocational Training _____
Gross Annual Income* _____ Home Phone #_____Cell # _____

Adoptive-Mother/Guardian_____ Date of Birth _____
First Last
Occupation _____ Employer _____
Highest Grade Completed _____ Other Vocational Training _____
Gross Annual Income* _____ Home Phone #_____Cell # _____

Marital status of parents _____ Date divorced, if applicable _____
Date of death of parent, if applicable _____ Which parent? _____

Indicate recent family stressors (financial concerns, births, deaths, marital conflicts, etc.): _____
_____
_____

Indicate any Department of Human Services or other social service involvement: _____
_____
_____

List all persons living in the home:

NAME	AGE	RELATIONSHIP TO CHILD

SCHOOL HISTORY:
Please bring all old report cards, school achievement, and other testing results that you can find or get from the schools.
Preschool: Did your child attend a program or day treatment program? ☐ NO ☐ YES
If yes, where and for how long:_____
_____

Home School: Is your child Home Schooled? ☐ NO ☐ YES If yes, what curriculum is used: _____

Kindergarten: Age began _____ Any Problems _____

School Age:
List all schools attended:

Name of School	Grades Attended	Dates Attended

Has your child repeated a grade(s) or been held back: ☐ NO ☐ YES
If yes, which grade and why:
_____

List extra-curricular, sport, or club activities of child: _____

Is your child currently receiving additional services through the school? ☐ NO ☐ YES

☐ Self-contained special education ☐ Resource ☐ Remedial/Chapter 1

☐ Speech/language therapy ☐ Occupational therapy (OT) ☐ Physical Therapy

☐ ABA Therapy ☐ School Based Therapy ☐ Other, please specify: _____

Date of last school testing: _____ Results of testing: _____

(Attach copies of testing if possible.)

Have you requested testing from the school? ☐ NO ☐ YES

Is any testing scheduled? ☐ NO ☐ YES If yes, when? _____

Are you satisfied with your child's placement? ☐ NO ☐ YES If no, why? _____

_____

What do you feel is your child's main problem at school? _____

_____

_____

What do you feel the school thinks is your child's main problem? _____

_____

PLEASE LIST THE NAMES AND ADDRESSES OF OTHER PROFESSIONALS WHO HAVE WORKED WITH YOUR CHILD BELOW AND ALSO ON YOUR AUTHORIZATION TO RELEASE INFORMATION FORMS *(INCLUDED IN PACKET)*:

NAME

Pediatrician _____

Occupational Therapist _____

Speech Pathologist _____

Physical Therapist _____

Health Department (Nurse)_____

Mental Health Professional_____

Specialist (please specify) _____

Other (please specify) _____

I certify that the information I have provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Patient or Adult Legally Responsible for Minor Child Patient

UAMS | Schmieding Developmental Center

519 Latham Dr.
Lowell, AR 72745
(479)750-0125, Fax (479)750-0323

AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, _____, hereby authorize Schmieding Developmental Center to release/request information from:

School District/Name: _____

Address: _____ _____
Street Address *City* *State* *Zip*

Phone: _____ Fax: _____

Information of:
Patient Name: _____ DOB: _____

The purpose of this authorization is for: _____ Payment _____ Treatment _____ Other: _____

Information to include:

- ☐ School Report
- ☐ Reports Card History
- ☐ Language Proficiency Testing
- ☐ Developmental/Psycho Ed Evaluation
- ☐ 504 Plan
- ☐ Behavior Evaluation/Plan
- ☐ Physical Therapy Evaluation
- ☐ Verbal Communication
- ☐ All Records
- ☐ Teacher Rating Form
- ☐ Achievement Test (Benchmark)
- ☐ MAC &/or ELDA Scores
- ☐ IFSP/IPP/IEP
- ☐ RTI / IRI Plan
- ☐ Speech Evaluation
- ☐ Occupational Therapy Evaluation
- ☐ Health Plan
- ☐ Other: _____

I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire _____ (date) OR 1 year from date signed.

The facility, its employees, and clinicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations. I agree to pay the cost of copying, supplies, labor, postage, and other expenses associated with the request as allowed by law.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

_____ _____ _____
Legal Representative Signature Relationship Date

UAMS Schmieding Developmental Center

519 Latham Dr.
Lowell, AR 72745
(479)750-0125, Fax (479)750-0323

AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, _____, hereby authorize Schmieding Developmental Center to release/request medical records, to include verbal communication, from the following individuals/clinics/hospitals:

PCP: _____ Phone: _____

ENT: _____ Phone: _____

Vision: _____ Phone: _____

Neurology: _____ Phone: _____

Genetics: _____ Phone: _____

Birth Hospital: _____ Phone: _____

Mental Health: _____ Phone: _____

ST, OT, PT: _____ Phone: _____

Other: _____ Phone: _____

Please list persons that may receive information (verbal or written) on behalf of your child.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Information of:
Patient Name: _____ DOB: _____

The purpose of this authorization is for: _____ Payment _____ Treatment _____ Other: _____

The purpose of this disclosure is for evaluating &/or treatment. I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire _____ (date) OR 1 year from date signed.

The facility, its employees, and clinicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations. I agree to pay the cost of copying, supplies, labor, postage, and other expenses associated with the request as allowed by law.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

_____ _____ _____

Legal Representative Signature Relationship Date