Driscoll Children's Hospital

Developmental & Behavioral Pediatric Clinic

Dear Parents or Legal Guardians,

We are very happy to have received a referral for your child and thank you for choosing Driscoll's Developmental & Behavioral Pediatrics. Our staff is committed to providing quality care in a fun and family-friendly environment to ensure our pediatric patients are comfortable and enjoy their visit(s).

Enclosed you will find new patient paperwork as well as one or more evaluation checklist and a self addressed pre-stamped envelope. Please take a few minutes to complete the information as this paperwork is very important for your child's evaluation. Once we have received the completed paperwork our office will contact you to schedule an appointment. ******Please note: having all the information thoroughly completed will allow us to create the very best treatment plan for your child.******

**Contact Information**
3533 S. Alameda St. 4th Floor Sloan Building
Corpus Christi, Texas 78411
Phone: 361-694-5650 Fax: 361-808-2063

Hours of operation: **M-F 8:00am-5:00pm**
DevelopmentalPediatric@dchstx.org

**To ensure a more productive visit:**

- Please arrive 10-15 min before your appointment time this allows the check in process to go smoothly. We have provided a copy of our cancellation, late & no show policy in your packet. Please review this policy as we value every opportunity to see your child.

- If you have other children and are able to make childcare arrangements, this would be very helpful during the evaluation since it reduces distractions for both the provider and parents. Please turn off/silence your cell phone to eliminate any additional interruptions.

**Please bring the following to each appointment:**

- List of all medications (prescriptions, over the counter and supplements)
- Insurance card(s)
- Copay/Co-insurance or Deductible (our office policy is to take payments at time of service)

Your first appointment will be approximately 1 to 1 ½ hours long, this gives the provider the opportunity to observe your child's behavior and interactions. We look forward to meeting you and your child. Please feel free to call us at 361-694-5650 with any questions or concerns about completing the paperwork.

Sincerely,

Maricela D. Gulbronson, MD FAAP
Sharon Antwi-Boasiako, MD

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Due to the high volume of patients needing our specialized services, our clinic has established the following guidelines regarding cancellation, no shows or late arrivals. The policy is as follows:

## Cancellations & No Shows

1. Please notify the Driscoll Developmental & Behavioral Pediatrics (361) 694-5650 of cancellations at least 24 hours before the scheduled appointment time. This allows the office to schedule another patient in need of an appointment.

2. Appointments not cancelled within 24 hours or failure to show up for a scheduled appointment will be considered a ***"no show"***.

3. Patients with ***Three (3)*** *"**no show**"* appointments within a 12-month period are subject to be dismissed from the practice.

4. ***Two (2)*** *"**no show**"* appointments for Initial Evaluations will result in the dismissal of the patient's referral.

## Late Arrivals

1. Patients who arrive ***10 minutes*** after their scheduled appointment time will be considered late. At the discretion of the provider patients may be seen with a reduced visit time or have to reschedule their appointment.

**Thank You in advance and we appreciate your cooperation!**

Driscoll Children's Hospital

# -PATIENT COPY-

## PAPERWORK CHECK LIST

*PLEASE RETURN COMPLETED PAPERWORK TO OUR OFFICE*
*SO THAT WE CAN SCHEDULE AN APPOINTMENT FOR YOUR CHILD*

- ☐ Family Information Sheet
- ☐ Patient History Forms (**4 pages**) (**Please fill out all pages completely**)
- ☐ Cancellation, No Show & Late Policy
- ☐ ***Copy** of Insurance Card **Front & Back** (with Subscriber's Information below)

Subscriber's Name: Primary_____Secondary_____

Subscriber's DOB: Primary_____Secondary_____

Subscriber's SSN#: Primary_____Secondary_____

Subscriber's Employer: Primary_____Secondary_____

Child's SSN# (Required to file Medicaid) _____

- ☐ All Inventory Checklists/Assessments from Parent, Teacher and Patient (if applicable)

## ADDITIONAL INFORMATION NEEDED

**If your child has had previous evaluations, been placed on medications or receives services from the school- Please include the following information**

- Copies of IEP and any Psycho-Educational testing
- Medical records and previous evaluations from Prescribing Provider, Neurologist, Speech & Language, Private Psychologist and ECI (Early Childhood Intervention)

- ☐ Interpreter needed? Yes ☐ No ☐ Language needed _____

*****Please note any other special needs _____**

Please keep the introduction letter and map these are included for your convenience.

**Thank You**

Driscoll Children's Hospital
Developmental & Behavioral Pediatric Clinic Staff

**Please send completed paperwork to:**
**Developmental & Behavioral Pediatrics**
**3533 S. Alameda Street 4th Floor Sloan**

Driscoll Children's Hospital

Corpus Christi, Texas 78411

# FAMILY INFORMATION SLIP

One form may be used for the entire family provided that the responsible party is the same for each child.

**Today's Date: _____**

**CHILDREN'S NAMES:**

| LAST | FIRST | MIDDLE | SEX | DATE OF BIRTH | SS# |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PT. ADDRESS:_____CITY_____STATE_____ZIP____**

*(THIS BOX IS FOR STAFF USE ONLY)*
**YEAR:_____INITIALS_____ YEAR:_____INITIALS_____**

**FATHER'S NAME: _____DOB_____SS#_____**
****ADDRESS IF DIFFERENT FROM ABOVE:_____**
**HOME PHONE #_____EMPLOYER_____WORK #_____**
**MOBILE#_____**

**MOTHER'S NAME: _____DOB_____SS#_____**
****ADDRESS IF DIFFERENT FROM ABOVE:_____**
**HOME PHONE #_____EMPLOYER_____WORK #_____**
**MOBILE#_____**

**IF DIVORCED OR SEPARATED LIST CUSTODIAL PARENT: _____**
**LIST ANY STEP PARENT AND RELATIONSHIP: _____**
**NEAREST RELATIVE NOT LIVING WITH YOU,** But close by:_____Phone#_____
**WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?_____**Phone#_____

**MEDICAL INSURANCE INFORMATION: (PRESENT CARD AT FRONT DESK) (LIST PRIMARY FIRST)**

| COMPANY | GROUP# | ID# | POLICY HOLDER'S NAME/RELATIONSHIP |
|---|---|---|---|
| | | | |

***IF YOU HAVE MEDICAID INSURANCE PLEASE SUBMIT YOUR CARD AT EACH VISIT. **PLEASE NOTE DRISCOLL CHILDREN'S HOSPITAL DEVELOPMENTAL AND BEHAVIORAL PEDIATRIC CLINIC MUST HAVE A REFERRAL FROM YOUR PRIMAY CARE PHYSICIAN.***

***As a parent, I understand I must give permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at Developmental & Behavioral Pediatric clinic.***

**If I cannot come with my child, I agree to let _____and/or_____**
**(Name & Relationship) (Name & Relationship)**
**give permission for any treatment. (Examples of persons to name here may be stepparent, grandparent, sitter, etc.)**

**If my child comes with anyone other than myself or the persons listed above, I agree to send with them a written note, with my signature, giving permission for treatment.**

*****Child must be 18 years of age to be treated without a parent present or to pick up a prescription*****

_____ _____ _____ _____
**Patients Signature (Date) Parent or Guardian Signature (Date) Initials**

Driscoll Children's Hospital

**Parent's E-Mail Address**:_____

**PLEASE COMPLETE ENTIRE APPLICATION**

Today's Date: _____ Child's Name: _____

DOB: _____

**PATIENT HISTORY FORM**

Person completing this form: _____Relationship to child:_____

Name child wants to be called: _____

**PURPOSE OF THE VISIT**

Describe what concerns you have about your child: _____

_____

_____

Previous evaluations for these concerns: _____

(Examples: School, ECI, Psychiatrists, Neurologists, Genetics)

What would you most like to happen with this visit: _____

What questions do you have for the doctor: _____

_____

List any services you child is currently receiving: _____

(*Speech, Occupational Therapy, Physical Therapy, ABA, include special services through school, 504, IEP, special classroom), other* _____

*Does he/she currently have *Individual Educational Program (IEP)? Y/N___ Section 504 Plan?* Y/N ___

If your child has been on any medications in the past, list with dose and reactions:

_____ _____

_____ _____

_____ _____

_____ _____

**CHILD'S HISTORY**

Describe your child's health: _____

Birth weight: _____ Delivery : C/S or SVD Complications at birth: _____

Current medications (Name and Dose):

_____ _____

_____ _____

_____ _____

_____ _____

Drug allergies:_____

Hospitalizations: _____ Psychiatric admission(s):_____

Surgeries: _____

Extended illnesses: _____

Significant injuries: _____

Describe your child's growth: _____

Describe your child's temperament: _____

When did your child begin school of preschool: _____ Repeated grade: _____

Current school: _____ Grade: _____

Driscoll Children's Hospital

**DEVELOPMENTAL HISTORY**

Describe what developmental concerns you have: _____

_____

At what age did you first suspect difficulties: _____

By what age did your child do the following things:

MOTOR

Crawl: _____
Sit without support: _____
Walk alone: _____
Ride a tricycle: _____
Ride a bicycle with training wheels: _____
Ride a bicycle without training wheels: _____

LANGUAGE

Babble: _____
Said first word: _____
Put 2 words together: _____

SOCIAL / SELF HELP

Smile: _____
Use a spoon to feed self: _____
Bladder trained: _____
Bladder trained at night: _____

Bowel trained: _____
Able to separate from Mom easily: _____
Able to dress oneself: _____

**In the list below, please circle any of these issues your child has had:**

Shyness with strangers
Refusal to go to school
Extreme restlessness
Trouble getting satisfied
Over reaction to sights or noises
Temper tantrums
Crying often and easily
Head banging
Trouble with eye contact
Making odd sounds, grunts or other noises
Eating non-foods
Trouble falling asleep
Noisy breathing/snoring
Looseness or floppiness

Problems with change of daily routine
Tendency to be overexcited
Difficulty getting consoled
Extreme reaction to tastes or touching
Irritability
High tolerance for pain
Self-destructive behaviors
Failure to be affectionate
Feeding difficulty
Colic
Trouble staying asleep
Stiffness or rigidity
CPS/CARE case for abuse: physical or sexual
Violent rule breaking behaviors

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## REVIEW OF SYSTEMS

**In the list below, please circle any of these problems your child has had:**

| | |
|---|---|
| Chronic pain | Unexplained fevers |
| Weight loss | Cancer |
| High cholesterol | Cataracts |
| Crossed eyes | Chronic ear infections |
| Chronic sinus infections | Chronic allergic symptoms |
| Heart murmur | Other heart problems |
| Asthma | Bronchiolitis |
| RSV | High blood pressure |
| Chronic Bronchitis | Cystic fibrosis |
| Other lung disorders | Chronic diarrhea |
| Chronic constipation | Reflux |
| Ulcer | Other stomach or bowel problem |
| Joint problems | Muscle problems |
| Skin problems | Chronic eczema |
| ADHD | Learning disabilities |
| Mental retardation | Autism |
| Seizures | Cerebral palsy |
| Depression | Anxiety |
| Kidney or bladder infections | Other kidney disease |
| Diabetes | Thyroid problems |
| Other glandular problems | Sickle cell anemia |
| Anemia | Other blood disease |
| Other _____ | Other _____ |

## SOCIAL HISTORY

PARENTS: ( ) Married ( ) Divorced ( ) Separated ( ) Other _____
Who does child live with? _____
Child's relationship with Mother: _____
Child's relationship with Father: _____
Siblings (names and ages): _____

Family circumstances: _____
*Biological Father:*
Name: _____ Age: _____
Present occupation: _____ School level completed: _____
General health: _____

*Biological Mother:*
Name: _____ Age: _____
Present occupation: _____ School level completed: _____
General health: _____

Was the child adopted? _____ At what age? _____
Circumstances of adoption: _____

*Adoptive Father:*
Name: _____ Age: _____
Present occupation: _____ School level completed: _____
General health: _____

*Adoptive Mother:*
Name: _____ Age: _____
Present occupation: _____ School level completed: _____
General health: _____

Has the child been in foster care? _____
Circumstances of foster care: _____
Foster parents: _____
Total number of placements: _____

**FAMILY HISTORY**

Who in the family has any of the following difficulties? (Only include biological family)
(This would include child's Father, Mother, Brothers, Sisters, Grandparents, Aunts, Uncles, and First Cousins)

**Please note next to the appropriate items the family member who has/had the problem**

Hyperactivity:_____
Trouble learning: _____
Mental retardation: _____
Repeated a grade in school: _____
Speech problems: _____
Behavior problems in school: _____
In trouble as a teenager: _____
Depression: _____
Anxiety: _____
ADHD: _____
Autism: _____

Asperger syndrome: _____
Bipolar disorder: _____
Schizophrenia: _____
Other emotional problems: _____
Drinking or drug abuse: _____
Birth defects: _____
Tics or Tourette's syndrome: _____
Blind/severely visually impaired: _____
Hearing impaired: _____
Seizures: _____
Died as an infant or child: _____

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**Patients Name:** _____

**DOB:** _____

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**Thank You in advance and we appreciate your cooperation!**

**I understand the above statements.**

**Signature:** _____ **Date:** ____/____/____