Driscoll Children's Hospital
Developmental Pediatric Medicine

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 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, TX 78411
Phone: (361) 694-5650 | Fax: (361) 808-2063
developmentalpediatric@dchstx.org

Hours of Operation
Monday - Friday, 8AM - 5PM

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 Gulbronson, MD
Medical Director, Developmental Medicine Clinic
Children's Physician Services of South Texas
Driscoll Children's Hospital

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Developmental Pediatric Medicine

Maricela D. Gulbronson, MD
Sharon Antwi-Boasiako, MD
3533 S. Alameda St., 4th Floor Sloan Building,
Corpus Christi, TX 78411
Phone: (361) 694-5650 | Fax: (361) 808-2063

Patients Name: _____ Date of Birth: _____

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 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.

I understand the above statements.

Signature: _____ Date: _____

Thank You in advance and we appreciate your cooperation!

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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 If Yes, 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 Clinic Staff

Please Send Completed Paperwork To:
Developmental & Behavioral Pediatrics
3533 S. Alameda St., 4th Floor Sloan Building,
Corpus Christi, TX 78411

Driscoll Children's Hospital
Developmental Pediatric Medicine

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 Information

Last Name: First Name: Middle Name: Sex: Date of Birth: Social Security Number:

_____

_____

_____

_____

Patent Address:_____ City:_____ State:_____ Zip Code:_____

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

Guardian/Father's Information

Name:_____ Date of Birth:_____ Social Security Number: _____
Address (if different form above): _____
Home Phone:_____ Mobile Phone:_____
Employer:_____ Work Phone:_____

Guardian/Mother's Information

Name:_____ Date of Birth:_____ Social Security Number: _____
Address (if different form above): _____
Home Phone:_____ Mobile Phone:_____
Employer:_____ Work Phone:_____

If Divorced or Separated List Custodial Parent: _____
List Any Step Parent and Relationship: _____
Nearest Relative Not Living with You, But Close By:_____ Phone Number:_____
Whom May We Contact in Case of an Emergency?_____ Phone Number:_____

Medical Insurance Information (Present Card At Front Desk and 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 Primary Care Physician.

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As a parent, I understand I must give permission for my child to receive medical treatment. If possible, I will come with my child for every appointment at developmental & behavioral pediatric clinic.

If I cannot accompany my child, I authorize the person(s) listed below to consent to treatment on my behalf (example of relationship here may be stepparent, grandparent, sitter, etc.).

Name:_____ Relationship:_____
Name:_____ Relationship:_____

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.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____
E-Mail Address:_____ Initials:_____

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PATIENT HISTORY FORM

Please complete entire application.

Today's Date: _____ Patient Name: _____ Date of Birth: _____
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 (ex: 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 (ex: Speech, Occupational Therapy, Physical Therapy, ABA—include special services through school, 504, IEP, special classroom): _____
Does he/she currently have Individual Educational Program (IEP)? ☐ Yes ☐ No Section 504 Plan? ☐ Yes ☐ No
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 ☐ 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: _____

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

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 CHECK 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 CHECK ANY OF THESE PROBLEMS YOUR CHILD HAS HAD:

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

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: _____

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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 like the 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: _____
Intellectual disability: _____
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: _____