Mary Bridge Children's Physical Medicine & Rehabilitation

DR. ROBERT COOPER & ALLYSON STOKER, ARNP

Phone: **253.403.4437** • Fax: 253.403.0091

If your child has ever been seen by the following specialists, please request that medical records be sent or faxed to our clinic prior to your visit. Once the required records are obtained we will call and schedule an ap-pointment for your child.

Please indicate specific specialties seen by your child:

1. Primary Care Physician: .....
2. Orthopedics ..... ❑ Yes ❑ No If yes, please list _____
3. Neurology ..... ❑ Yes ❑ No If yes, please list _____
4. Neurosurgery ..... ❑ Yes ❑ No If yes, please list _____
5. Physiatry ..... ❑ Yes ❑ No If yes, please list _____
6. Recent Inpatient hospitalization .... ❑ Yes ❑ No If yes, please explain _____
7. Physical therapy ..... ❑ Yes ❑ No If yes, please list _____
8. Occupational therapy ❑ Yes ❑ No If yes, please list _____
9. Speech therapy ..... ❑ Yes ❑ No If yes, please list _____

Please note that medical records are not needed by GI, Urology, Psychology

Other subspecialty involvement:

10. Gastroenterology ..... ❑ Yes ❑ No If yes, please list _____
11. Urology ..... ❑ Yes ❑ No If yes, please list _____
12. Psychology ..... ❑ Yes ❑ No If yes, please list _____

By completing the questionnaire prior to your appointment at Mary Bridge Pediatric Rehab Medicine Clinic, you will be helping us better understand your questions and the concerns which are affecting your child and your family. You will also provide us with a great deal of important information, which will allow us to work with you more effectively.

Please answer these questions as completely as possible.

Child's name: _____ Date of birth: _____ Sex: _____

Mother's name: _____ Age: _____

Occupation: _____

Father's name: _____ Age: _____

Occupation: _____

Address: _____

Telephone: Home: _____ Work: _____

Name of person completing form: _____

Relationship to child: Date form completed: _____

Primary Language: ____ English ____ Spanish ____ Russian ____ Other _____

Primary Care Provider: _____

Who suggested that you receive services? _____

Patient Identification - Always Attach Patient Label

Name:

MRN#:

CSN#:

Age /Sex:

PEDIATRIC PHYSICAL MEDICINE INTAKE REPORT (Page 1 of 5)

Mary Bridge Children's
Hospital · Clinics · Foundation

88-9981-2 (Rev. 9/17)

I. Purpose of Appointment

What are your major concerns about your child? _____

_____

Has your child received an evaluation or treatment for these problems before? If yes, with whom and when?

_____

_____

What services are you hoping to receive (e.g., diagnosis, testing, therapy services)? _____

_____

II. Birth History

This section is to be completed by the child's mother, if possible. Please indicate:

This child was the product of pregnancy number _____

Did you receive regular medical care during this pregnancy? ❑ Yes ❑ No

Pregnancy History: Mother's Health During Pregnancy

	Yes	No	Unknown	Explain	Months of Pregnancy
Drugs	____	____	____	_____	_____
Tobacco	____	____	____	_____	_____
Medications	____	____	____	_____	_____
Alcohol	____	____	____	_____	_____
Infections	____	____	____	_____	_____
Bodily Injury	____	____	____	_____	_____
Other	____	____	____	_____	_____

Did you carry this baby a full 9 months? ❑ Yes ❑ No

If no, please indicate length of pregnancy in weeks: _____

Problems with your pregnancy? ____ illness ____ injury ____ fainting spells ____ bleeding ____ anemia ____ toxemia ____ placenta previa ____ operations

Problems with your delivery? ____ emergency c-section ____ slow heart rate ____ fever ___ cord around neck ____ delivery aided by forceps or suction

How much did your baby weigh at birth? _____ Apgar scores at 5 min. ____ at 10 min. _____

Problems with infant at birth? ___ Jaundice ___ feeding difficulty ___ respiratory problems ___ limpness ___ prolonged NICU stay ___ medications

Infant with discharged to home in _____ days.

Mother was discharged in ____ days.

III. Developmental History:

At what age did your child do the following?

Establish eye contact _____ Begin babbling _____

Speak his/her first words _____ Roll over _____

Sit alone without support _____ Crawl _____

Walk without support _____ Feed her/him self _____

Dress her/him self _____ Toilet trained _____

IV. Home Architecture

Is your home: one-story_____ two-story_____ three-story_____

Stairs to enter? ❑ Yes ❑ No Ramp access? ❑ Yes ❑ No

V. Education

Attending school? ❑ Yes ❑ No If yes: ____Public ____Private

Name of school _____ Grade _____

School nurse or contact person _____

Does your child have an IEP, 504 or other plan used at school? ❑ Yes ❑ No

VI. Social History

Please list the persons who are currently living in the home with the child:

Name	Sex	Age	Relationship to child

Do any of child's siblings have problems with health, development, or behavior? ❑ Yes ❑ No

If yes, please explain _____

Is this a foster child? ❑ Yes ❑ No _____

Is this child adopted? ❑ Yes ❑ No _____

Are there any stressors in the family which may be affecting your child? ❑ Yes ❑ No

If yes, please explain : _____

Parents are:

Married: _____ Separated: _____ Divorced: _____

Widowed: _____ Unmarried: _____

If parents are divorced, who has legal custody? _____

VII. Medical History

In the last 6 months would you describe your child as healthy? _____

Has your child been hospitalized? ❑ Yes ❑ No

If yes, list ages and reasons:_____

Has your child had any chronic illnesses? ❑ Yes ❑ No

If yes, please explain:_____

Has your child taken any medications in the past for muscle spasticity? ❑ Yes ❑ No

If yes, please list:_____

Has your child ever had Botox? ❑ Yes ❑ No

If yes, when and where:_____

Does your child have seizures? ❑ Yes ❑ No

Has your child ever had a head injury? ❑ Yes ❑ No

If yes, please describe: _____

Has your child ever had a CT scan, MRI or EEG? ❑ Yes ❑ No

If yes, please provide details: _____

Has your child had recent x-rays of bones? ❑ Yes ❑ No

If yes, please provide details: _____

Does your child have trouble sleeping through the night? ❑ Yes ❑ No

If yes, please describe concern:_____

How many hours they are sleeping? _____

VIII. Surgical History:
Has your child had any of the following surgeries?

PDA (heart) repair ..... ❑ Yes ❑ No
Shunt in brain ..... ❑ Yes ❑ No
Strabismus surgery ..... ❑ Yes ❑ No
Tracheotomy ..... ❑ Yes ❑ No
Gastric tube/J-Tube ..... ❑ Yes ❑ No
Nissen (fundoplication) ..... ❑ Yes ❑ No
Tendon lengthening (heel cords, hamstrings, hip abductors, other) ..... ❑ Yes ❑ No
Bone surgeries (de-rotation of leg bones, hip reconstruction, or ankle fusion) ..... ❑ Yes ❑ No
Baclofen pump ..... ❑ Yes ❑ No

VIIII. Medical History of the Biological Family
Has anyone in this patient's biological family ever had any of the following conditions? Check all that apply.

	Birth Mother	Birth Father	Mother's Family	Father's Family	Siblings of Patient
Muscle disease, cerebral palsy, nerve disease					
Birth defects					
Developmental disabilities					
Learning problems					
Seizures					
Mental/emotional problems					
Vision/hearing problems					
Health problems					

X. Activities of Daily Living:

Feeding: ____ assists ____ dependent ____ independent
Bathing : ____ assists ____ dependent ____ independent
Dressing: ____ assists ____ dependent ____ independent
Undressing: ____ assists ____ dependent ____ independent
Toileting: ____ assists ____ dependent ____ independent

COMMUNICATION: Check all that apply:

No Problems_____ Age Appropriate_____ Delayed_____ Non-Verbal_____
Dysarthric_____ Sign Language_____ Picture Board_____ Aphasic _____
Augmentative Communication _____ Device_____

Mobility:

Independent_____ Age Appropriate_____ Rolls_____ Scoots_____
Crawls_____ Creeps_____ Dependent_____

Sits:

Independent_____ When Propped_____ "W"_____ Only When Supported_____

Walks:

Independent_____ With Orthotics_____ Canes_____ Walker_____

Runs: ❑ Yes ❑ No
Climbs Stairs: ❑ Yes ❑ No Independently_____ Holding Rail_____
Step To_____ Alternating Steps_____

EQUIPMENT: Check all that apply

None_____ Lift_____ Cane_____ Medical Stroller_____
Bath Seat_____ Walker_____ Chair_____ Stander_____
Reverse Walker_____ Power Wheelchair_____ Manual Wheelchair_____ Adapted Car Seat_____
Positioning or Feeding_____ _____

Equipment needing repair: _____

_____

New equipment needed: _____

_____

Equipment on order: _____ Vendor: _____

Preferred Durable Medical Equipment Vendor: _____

ORTHOTICS: Check all that apply

None_____
Calf height orthotic (Left/Right) _____
with hinge? (Yes/No)_____
Above knee brace (Yes/No)_____
Resting hand splint_____
Thumb abduction splint_____
Wrist extension splint_____
Orthotics fitting well? ❑ Yes ❑ No

In shoe orthotic (Left/Right)_____
Night boot (Left/Right)_____
Ankle height orthotic (Left/Right)_____
Knee extension splint_____
Weight bearing mitt_____
Truncal orthosis (soft/hard)_____

* ***Please bring orthotics to your appointment***

** **You will notice in your new patient package that there is a Release of Medical Information Form , please fill out with any specialist and imaging that your child may have inquired at that is NOT within the Multicare Organization. Please obtain school therapy notes and IEP's to bring to appointment if applicable. Thank you and we look forward to meeting you soon. .**

MY RIGHTS

Once MultiCare discloses your health information, the recipient may re-disclose your information and privacy laws may no longer protect your information. Federal and state laws forbid reporting of information about alcohol abuse treatment, sexually transmitted diseases, or mental health issues without written consent of the patient, or by law.

I understand I can withdraw this consent form at any time. Withdraw requests must be submitted in writing to Health Information Management Department, P.O. Box 5299, Mailstop 1002-1-HIM, Tacoma, WA 98405, Attention HIM/ROI. Withdrawing this consent would not affect any actions or reports already made by MultiCare Health System and will not affect MultiCare's usage of the information to bill for services.

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in research study, or
- To receive health care when the purpose is to create health care information for a third party.

I understand I may be charged a fee for the copies. Cost information can be obtained from the Health Information Management Department on 253.403.2433.

MULTICARE USE ONLY

❑ **This request was completed and Medical Records were given to the patient at the clinic or hospital. Please scan this release into Epic.**

DRUG AND ALCOHOL ABUSE INFORMATION

Federal law (42 CFR Part 2) forbids any release of this information except with written consent of the person whose information it is. The parent or legal guardian of the minor child may consent unless the patient is 13 or older. In that case, the signature of the patient is required. A general authorization for the release of information is NOT enough for this purpose. The Federal rules limit any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

MENTAL ILLNESS INFORMATION

State law forbids any disclosure of mental health information without specific written consent of the person whose information it is. The parent or legal guardian of a minor child may consent unless the minor patient is 13 or older. In that case, signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (See RCW 71.05.390)

SEXUALLY TRANSMITTED DISEASE INFORMATION (Includes HIV/AIDS)

State law forbids any disclosure of this information without specific written consent of the person whose information it is. The parent or legal guardian of the minor child may consent unless the patient is 14 or older. In that case, the signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (See RCW 70.24 and WAC 246-100.)

CONSENT FOR MINOR

A signature of a minor patient is required to release information concerning care for: (1) birth control and pregnancy-related care, (2) sexually transmitted disease information (including HIV/AIDS) if the minor is 14 or older, (3) substance abuse diagnosis or treatment if the minor is 13 or older, and (4) outpatient mental health information if the minor is 13 or older.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

A general authorization for the release of medical or other information is NOT enough for this purpose. The Federal rules limit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

GENETIC INFORMATION

Genetic information includes many things, ranging from the results of any genetic testing, to your family's medical history. It also includes information about any genetic disorders or conditions you have or might have, as well as any genetic services you have received, are currently receiving, or have requested to receive. Also included is genetic information about a pregnancy, fetus, or embryo (including if in-vitro fertilization, or other assisted reproductive technology, is used).

Patient Name *(Please print full name)*: _____ **Date of Birth:** _____

Address: _____ **Age:** _____

Phone #: _____

❑ Paper Copy ❑ Electronic Copy (CD-ROM) ❑ Verbal health care information can be given to: _____
(Full Name & Date of Birth)

❑ Electronic Delivery: If you would like to receive your records electronically via our secure Patient Portal please provide your email address: _____. You will be notified by email when your records are ready to be downloaded. For further information, please go to: http://patientportal.iodincorporated.com/MultiCare (Charges may apply for records copied)

Purpose of Disclosure

❑ Further Medical Care ❑ Personal ❑ Billing ❑ Insurance Eligibility/Benefits

❑ Legal Investigation/Action ❑ Other: _____

Information may be disclosed by: (select a box)

❑ **MultiCare Health System** (*Unless otherwise specified, we will provide records from all MultiCare locations* of service applicable to the date(s) of service noted. Please specify if you would like records located to a specific MultiCare hospital, clinic, or other site-of-service).

--OR--

❑ Provider, Name/Facility: _____

Address: _____ Phone: _____ Fax: _____

Information may be disclosed to:

Name/Facility: **Mary Bridge Physical Medicine Rehab**

Phone: **253.403.4437 opt 4** Fax: **253.403.0091**

Address: **311 South L St., Tacoma WA 98405**

Information to be disclosed:

Dates of Service and/or Conditions Treated: _____

Select type(s) of information that may be disclosed:

Routine Medical Records Sets --------OR--------

❑ **Clinic Records** (Includes: Office Visit, Laboratory, Radiology, Medication Record, Immunization Record)

❑ **Hospital Records** (Includes: History and Physical, Discharge Summary, Operative Report, Consultations, Emergency, Laboratory, Radiology)

❑ **Billing Records**

❑ **Copies of Images and Films**

Specific Medical records Documents Only

❑ Discharge Summary/Note
❑ History and Physical
❑ Operative Report
❑ Radiology Report
❑ Laboratory Report
❑ Pathology Report
❑ Emergency Report
❑ Immunization Record
❑ Nursing Notes
❑ Medication Notes
❑ Progress Notes/Clinic Notes
❑ Rehab Therapy (PT/OT/ST
❑ Other (please specify): _____

I authorize the release of the below information: (initial all that apply)

_____ HIV (AIDS virus) * see reverse _____ Sexually Transmitted diseases _____ Genetic Information and Indicators

_____ Psychiatric disorder or mental health _____ Drug or alcohol abuse

**** * * NOTE: If this section is not completed, records of this type (if they exist), will not be released. * * ****

*** If the records requested above will result in any charges, I understand I will be contacted with an estimate of those charges before the records are produced. MultiCare's charges for release of information vary depending upon the nature and extent of the records requested. For more information, please go to http://www.multicare.org/medical-records*

This Authorization Expires in 90 days: (Unless a date or event is specified here): Date/Event: _____

_____ _____ *Legal Authority: _____

Signature of Patient/Representative **Date/Time** **(If signed by person other than the patient, print name and identify relationship.)*

Patient Identification - Write in or attach patient label

Name:

MRN #:

CSN #:

Age / Sex:

CONSENT TO USE OR RELEASE MY HEALTH CARE INFORMATION

MultiCare
BetterConnected