DUE TO EXISTING LONG WAITING LISTS, MANY OF OUR SERVICES ARE CURRENTLY UNABLE TO ACCEPT NEW APPOINTMENT REQUESTS OR REFERRALS. PLEASE DO NOT SUBMIT REQUESTS FOR THE SERVICES LISTED BELOW:

Page 10 of the APPOINTMENT REQUEST / SELF REFERRAL FORMS has descriptions of the types of services currently available at Child Study Center.

<table>
<thead>
<tr>
<th>NOT ACCEPTING NEW PATIENTS</th>
<th>ADHD AND DEVELOPMENTAL-BEHAVIORAL PEDIATRIC CLINIC</th>
<th>Medical evaluations and treatment as needed including medication management for patients, age birth to 18 years, with complex neurodevelopmental disorders including ADHD and other disruptive behavior disorders, autism spectrum disorders, language disorders, and intellectual disability, among others.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOT ACCEPTING NEW PATIENTS</td>
<td>BEHAVIOR CLINIC AND PARENT CHILD INTERACTION THERAPY (PCIT)</td>
<td>Assessment and treatment services for children and adolescents with a wide variety of emotional and behavioral problems.</td>
</tr>
<tr>
<td>NOT ACCEPTING NEW PATIENTS</td>
<td>JUMPSTART / AUTISM EVALUATION CLINIC</td>
<td>Evaluations for children age 6 years 11 months old and younger with suspected autism spectrum disorders.</td>
</tr>
<tr>
<td>NOT ACCEPTING NEW PATIENTS</td>
<td>PEDIATRIC NEUROPSYCHOLOGY CLINIC</td>
<td>Comprehensive neuropsychological evaluations for patients age 2 to 18 with medical, neurological, and/or neurodevelopmental disorders.</td>
</tr>
<tr>
<td>NOT ACCEPTING NEW PATIENTS</td>
<td>SPECIALIZED ASSESSMENT CLINIC</td>
<td>Psychological evaluations for children ages 5 and older for a variety of problems such as Autism, ADHD, Emotional/Behavioral disturbances, and learning disabilities. Clinic also provides outpatient Cognitive Behavior Therapy services. This is NOT a medical evaluation.</td>
</tr>
</tbody>
</table>

For other resources, we highly recommend you contact Sooner Success. It is a program offered through the OU Child Study Center that helps families raising a child with special needs find resources in their community. Their website and county coordinators can help families navigate community resources in general. Their website has a detailed list of several other mental healthcare providers in the community that may be able to help meet your family’s needs. The list also includes providers outside the metro area that fit a wide range of pediatric healthcare needs. We hope this information will be helpful to your family in finding resources for their child and connecting them to other helpful services. To view the full list of resources, call toll free 1-877-441-0434 or visit [http://soonersuccess.ouhsc.edu/Resources/ChildStudyCenterResourcesList.aspx](http://soonersuccess.ouhsc.edu/Resources/ChildStudyCenterResourcesList.aspx)
Child Study Center
Appointment Request / Self Referral Instructions

The following 10 page “CHILD STUDY CENTER APPOINTMENT REQUEST / SELF REFERRAL FORMS” are required to request an appointment at the Child Study Center. Please include copies of both sides of insurance cards with all requests for appointments. If applicable and available, please copy (on one side only, no front and back copies, please) and attach any records of previous evaluations, hearing tests, and school forms like “IEP”s or “504 Plans.” You may use a separate sheet of paper to write more than space allows on the referral forms. **Your child’s name and date of birth are required on each page being submitted.** Remove all staples and paperclips. Please do not submit double sided copies; documents should have print on only one side of each page.

If the child’s insurance requires a referral such as Soonercare, the Primary Care Physician *is required* to submit a physician referral.

If the child is in **DHS Custody or Foster Care**, the DHS caseworker *is required* to submit signed consent forms. Please contact us to receive these forms for completion.

Please Mail or Fax all documents to:

Child Study Center
New Appointments and Referrals
1100 NE 13th Street
Oklahoma City OK 73117
Phone: 405-271-5700
Fax: 405-271-2992

When all required documents are received, the request will be processed and the family will be contacted. Please be aware there could be a substantial wait before you hear from us and an appointment may be scheduled. At this time, **some of our clinics are unable to accept new appointment requests**. Please check page 10 of the appointment request forms to make sure we are able to provide the type of services you are needing and only submit requests for available services.

For more resources, call toll free 1-877-441-0434 or visit http://soonersuccess.ouhsc.edu/Resources/ChildStudyCenterResourcesList.aspx
# CHILD STUDY CENTER

## APPOINTMENT REQUEST / SELF REFERRAL FORMS

**PATIENT NAME:**

<table>
<thead>
<tr>
<th>FIRST</th>
<th>MIDDLE</th>
<th>LAST</th>
<th>GENDER: □ M □ F</th>
</tr>
</thead>
</table>

**DATE OF BIRTH:**

**AGE:**

**SOCIAL SECURITY #:**

**MAILING ADDRESS:**

<table>
<thead>
<tr>
<th>CITY:</th>
<th>STATE:</th>
<th>ZIP:</th>
<th>COUNTY:</th>
</tr>
</thead>
</table>

**PREFERRED PHONE #:**

PLEASE INDICATE TYPE: CELL HOME OTHER

**ALTERNATE PHONE #:**

PLEASE INDICATE TYPE: CELL HOME OTHER

**PARENT/CAREGIVER NAME(S):**

<table>
<thead>
<tr>
<th>PARENT/CAREGIVER TYPE (CHECK ALL THAT APPLY):</th>
<th>□ BIOLOGICAL PARENT</th>
<th>□ GRANDPARENT</th>
<th>□ ADOPTIVE PARENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ STEP PARENT</td>
<td>□ LEGAL GUARDIAN</td>
<td>□ Foster Parent**</td>
<td>□ other</td>
</tr>
</tbody>
</table>

**PARENT/CAREGIVER EMAIL:**

**GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT OF SERVICES):**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DATE OF BIRTH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOCIAL SECURITY #:</td>
<td>RELATIONSHIP TO PATIENT:</td>
</tr>
<tr>
<td>MAILING ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>PHONE #: PREFERRED:</td>
<td>ALTERNATE PHONE #:</td>
</tr>
<tr>
<td>EMAIL:</td>
<td>EMPLOYER:</td>
</tr>
</tbody>
</table>

**PATIENT'S ETHNICITY:**

□ NON-HISPANIC □ HISPANIC □ UNKNOWN □ REFUSED

**PATIENT'S RACE:**

□ AFRICAN AMERICAN/BLACK □ AMERICAN INDIAN OR ALASKAN □ ASIAN □ WHITE

□ NATIVE HAWAIIAN OR OTHER PACIFIC ISLAND □ OTHER (SPECIFY):

**PATIENT'S LANGUAGE PREFERENCE:**

**TRANSLATOR NEEDED?** □ YES □ NO

**IF CANCELLATION RESULTING IN AVAILABLE APPOINTMENT OCCURRED, COULD YOU COME ON SHORT NOTICE?**

□ NO  □ YES  IF YES, HOW MUCH NOTICE DO YOU NEED? □ 1 HOUR  □ 4 HOURS  □ OTHER

**WHAT PHONE NUMBER SHOULD WE CALL TO CONTACT YOU IN THIS SITUATION?**

**IS PATIENT IN DHS CUSTODY?**

□ NO  □ YES  * □ YES If YES, provide Caseworker information

<table>
<thead>
<tr>
<th>DHS CASEWORKER NAME:</th>
<th>CASEWORKER FAX #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASEWORKER CELL PHONE #:</td>
<td>CASEWORKER OFFICE PHONE #:</td>
</tr>
<tr>
<td>CASEWORKER EMAIL:</td>
<td>CASEWORKER COUNTY:</td>
</tr>
</tbody>
</table>

**INSURANCE INFORMATION - PROVIDE COPIES OF BOTH SIDES OF INSURANCE CARD(S):**

**NAME OF PRIMARY INSURANCE COMPANY:**

<table>
<thead>
<tr>
<th>POLICY HOLDER NAME:</th>
<th>POLICY ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY HOLDER DATE OF BIRTH:</td>
<td>POLICY GROUP / PLAN #:</td>
</tr>
<tr>
<td>POLICY HOLDER RELATIONSHIP TO PATIENT:</td>
<td>POLICY HOLDER EMPLOYER:</td>
</tr>
</tbody>
</table>

**NAME OF SECONDARY INSURANCE COMPANY:**

<table>
<thead>
<tr>
<th>POLICY HOLDER NAME:</th>
<th>POLICY ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY HOLDER DATE OF BIRTH:</td>
<td>POLICY GROUP / PLAN #:</td>
</tr>
<tr>
<td>POLICY HOLDER RELATIONSHIP TO PATIENT:</td>
<td>POLICY HOLDER EMPLOYER:</td>
</tr>
</tbody>
</table>

**PATIENT'S REGULAR DOCTOR (PRIMARY CARE PHYSICIAN - PCP)?**

<table>
<thead>
<tr>
<th>PCP NAME:</th>
<th>FACILITY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>PCP PHONE #:</td>
<td>FAX#:</td>
</tr>
</tbody>
</table>

**PRINTED NAME OF PERSON COMPLETING THESE FORMS:**

**RELATIONSHIP TO PATIENT:**

**DATE FORMS COMPLETED:**

---

Child Study Center & Center on Child Abuse and Neglect  
1100 NE 13th St  Oklahoma City OK 731107  Phone: 405-271-5700  Fax: 405-271-2992  
Revised 9-2018

CHILD STUDY CENTER APPOINTMENT REQUEST/SELF REFERRAL FORMS PAGE 1 OF 10
CONCERNS:

Please tell us, in your own words, what your main concerns are for this child and why you are seeking this appointment. (For example: Medication consult, ADHD evaluation and treatment, counseling, problem behaviors, anxiety, abuse, trauma, learning impairments, dyslexia, speech delays, etc.) If learning problems, please specify the social and emotional impact of impairments. If Autism, please specify symptoms (nightmares, not getting along with others, physically aggressive, developmental delay, etc.) Please use a separate sheet if you need to write more than space allows. Please attach copies of any records of previous evaluations, hearing tests, school forms like IEP’s or 504 plans.

CHECK ALL SYMPTOMS OR BEHAVIORS THAT APPLY TO THIS CHILD:

☐ AGGRESSIVE
☐ ANGRY
☐ ANXIOUS/SCARED
☐ ARGUES
☐ CHRONIC ILLNESS
☐ CLINGY
☐ CONSTIPATION
☐ CRIES OFTEN/VERY UPSETTABLE
☐ DEPRESSED
☐ DOESN’T FOLLOW DIRECTIONS
☐ DOESN’T PAY ATTENTION
☐ DOESN’T PLAY WELL WITH OTHER CHILDREN
☐ DOESN’T SEEM TO UNDERSTAND
☐ EXTREME TANTRUMS
☐ FLAPS HANDS
☐ GROWTH CONCERNS
☐ HEARING LOSS
☐ HIGH PAIN TOLERANCE
☐ HYPERACTIVE
☐ KICKED OUT OF DAY CARE/SCHOOL
☐ LEARNING DIFFICULTIES
☐ LINES THINGS UP
☐ LYING
☐ NOT TALKING WELL
☐ PICKY EATER
☐ SENSITIVE TO SOUNDS
☐ SENSITIVE TO TEXTURES
☐ SPINS THINGS OR SELF
☐ TOILETING CONCERNS
☐ OTHER - DESCRIBE BELOW
**MEDICAL HISTORY**

**HOW WOULD YOU DESCRIBE THIS CHILD'S OVERALL HEALTH?**

- [ ] POOR
- [ ] FAIR
- [ ] GOOD
- [ ] VERY GOOD
- [ ] EXCELLENT

**HAS THIS CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? CHECK ALL THAT APPLY**

- [ ] EYES CROSSING/LAZY EYE
- [ ] WEARS GLASSES
- [ ] OVERNIGHT HOSPITAL STAY
- [ ] HEART PROBLEMS
- [ ] WEARS GLASSES
- [ ] EARS TUBES
- [ ] HEART PROBLEMS
- [ ] OVERNIGHT HOSPITAL STAY
- [ ] OTHER - DESCRIBE

---

<table>
<thead>
<tr>
<th>CHILD</th>
<th>BLOOD RELATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INDICATE IF THIS CHILD OR A BLOOD RELATIVE OF THIS CHILD HAS EVER BEEN DIAGNOSED, EVALUATED, OR TREATED FOR ANY OF THE FOLLOWING**

- AUTISM SPECTRUM DISORDER
- ASPERGERS DISORDER
- PERVERSIVE DEVELOPMENTAL DISORDER (PDD)
- DEVELOPMENTAL DELAY
- INTELLECTUAL DISABILITY (FORMERLY MENTAL RETARDATION)
- EMOTIONALLY DISTURBED (A SCHOOL DIAGNOSIS)
- ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
- OPPOSITIONAL DEFIENT DISORDER (ODD)
- ANXIETY DISORDER/PANIC ATTACKS
- BIPOLAR DEPRESSION
- DEPRESSION
- SCHIZOPHRENIA
- ATTACHMENT DISORDER
- POST TRAUMATIC STRESS DISORDER (PTSD)
- OBSESSIVE-COMPULSIVE DISORDER (OCD)
- SEPARATION ANXIETY DISORDER
- GENETIC DISORDER
- SEIZURE DISORDER
- HEART DISEASE/SUDDEN DEATH AT YOUNG AGE
- LEARNING DISABILITY
- SPECIAL EDUCATION
- OTHER - DESCRIBE

---

Revised 5-2018

CHILD STUDY CENTER APPOINTMENT REQUEST/SELF REFERRAL FORMS PAGE 3 OF 10
**CHILD STUDY CENTER**

**APPOINTMENT REQUEST / SELF REFERRAL FORMS**

<table>
<thead>
<tr>
<th>MEDICATIONS/HERBS/TREATMENTS/SPECIAL DIETS</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ALLERGIES**

**IS THIS CHILD ALLERGIC TO ANY MEDICATIONS?** □ YES □ NO

**IF YES, NAME OF MEDICATION**

<table>
<thead>
<tr>
<th>DATE OF MOST RECENT REACTION</th>
<th>SYMPTOMS EXPERIENCED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IS THIS CHILD ALLERGIC TO ANY FOODS?** □ YES □ NO

**IF YES, NAME OF FOOD**

<table>
<thead>
<tr>
<th>DATE OF MOST RECENT REACTION</th>
<th>SYMPTOMS EXPERIENCED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IS THIS CHILD ALLERGIC TO ANYTHING ELSE?** □ YES □ NO

**IF YES, WHAT**

<table>
<thead>
<tr>
<th>DATE OF MOST RECENT REACTION</th>
<th>SYMPTOMS EXPERIENCED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DATE OF MOST RECENT HEARING TEST**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DATE OF MOST RECENT VISION TEST**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEVELOPMENTAL HISTORY

INDICATE WHAT YOU FEEL IS THIS CHILD'S DEVELOPMENT IN THE FOLLOWING AREAS

- PHYSICAL DEVELOPMENT
- MOTOR SKILL DEVELOPMENT
- EMOTIONAL DEVELOPMENT
- ACADEMIC DEVELOPMENT
- LANGUAGE DEVELOPMENT
- INTELLECTUAL AND THINKING SKILLS DEVELOPMENT
- SOCIAL DEVELOPMENT
- PROBLEM SOLVING SKILLS
- FINE MOTOR SKILLS
- DAILY LIVING SKILLS (LIKE GETTING DRESSED OR TOILETING)
- RELATIONSHIP WITH SIBLINGS
- RELATIONSHIP WITH PARENTS AND CAREGIVERS

AT WHAT AGE (IN MONTHS) DID THIS CHILD:

- CRAWL
- TAKE FIRST STEP
- WALK
- RUN

AT WHAT AGE (IN MONTHS) DID THIS CHILD SPEAK:

- FIRST WORD
- 2 WORD PHRASES
- FULL SENTENCES

HOW DOES THIS CHILD COMMUNICATE - CHECK ALL THAT APPLY

- GESTURES
- WORDS
- PHRASES
- SENTENCES

OTHER:

WHAT DOES THIS CHILD DO WITH A PENCIL - CHECK ALL THAT APPLY

- SCRIBBLE
- COPY A CIRCLE
- COPY A SQUARE
- COPY A TRIANGLE
- DRAW A LINE
- DRAW A SIMPLE PERSON
- DRAW A PERSON WITH MANY BODY PARTS
- DRAW RECOGNIZABLE THINGS

OTHER:
EDUCATION
AGE AT WHICH YOU OR OTHERS BECAME CONCERNED ABOUT THIS CHILD’S DEVELOPMENT

DOES THIS CHILD ATTEND SCHOOL □ YES □ NO

WHAT GRADES DOES THIS CHILD MAKE □ A’S □ B’S □ C’S □ D’S □ F’S

HAS THIS CHILD EVER REPEATED A GRADE □ YES □ NO

NAME OF CURRENT SCHOOL ____________________________ GRADE ___________

TEACHER’S NAME ____________________________ CITY ____________________________

DO YOU HAVE ANY CONCERNS REGARDING THIS CHILD’S EDUCATIONAL PERFORMANCE
□ NO □ YES - DESCRIBE ____________________________

INDICATE ANY SERVICES PAST OR PRESENT RELATED TO THIS CHILD

PROVIDE ANY RECORDS AVAILABLE OF THESE EVALUATIONS, SERVICE PLANS, AND DIAGNOSTIC TESTING

DATE SERVICE BEGAN ____________________________ DATE SERVICE ENDED ____________________________

CURRENT □ PAST □ ON WAITING LIST □ INTERESTED □

EARLY INTERVENTION / SOONER START
DEVELOPMENTAL DELAY PRESCHOOL
HEAD START
INDIVIDUALIZED EDUCATION PLAN (IEP)
PRE-K
SPEECH THERAPY
OCCUPATIONAL THERAPY
PHYSICAL THERAPY
SOCIAL SKILLS GROUP
COUNSELING
PARENTING CLASS
BEHAVIOR THERAPY
OTHER

More Information:

_____________________________ ____________________________

_____________________________ ____________________________

_____________________________ ____________________________

_____________________________ ____________________________

_____________________________ ____________________________

_____________________________ ____________________________

_____________________________ ____________________________
**HOME AND FAMILY**

**LIST EVERYONE WHO LIVES WITH THIS CHILD**

<table>
<thead>
<tr>
<th>Full Time</th>
<th>Part Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF INDIVIDUAL**

**RELATIONSHIP TO CHILD**

<table>
<thead>
<tr>
<th>Full Time</th>
<th>Part Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HAS THIS CHILD LIVED IN OTHER HOMES PRIOR TO THE CURRENT HOME**

- [ ] Yes
- [x] No

**WHO PROVIDES SUPPORT TO THE PRIMARY CAREGIVER IN CARING FOR THIS CHILD - CHECK ALL THAT APPLY**

- [ ] Child’s Immediate Family
- [ ] Caregiver’s Immediate Family Like Grandparents
- [ ] Child Support Payments
- [ ] Housing Assistance
- [ ] Social Security
- [ ] Disability
- [ ] Welfare
- [ ] TANF
- [ ] SoonerCare / Medicaid
- [ ] Private Insurance
- [ ] WIC / Food Stamps / EBT
- [ ] Free/Reduced School Meals
- [ ] Unemployment Payments
- [ ] Parent/Family Networks
- [ ] Friends
- [ ] Church
- [ ] Support Group
- [ ] Daycare
- [ ] Tribal Support / Tribal Affiliation
- [ ] Energy Assistance
- [ ] More Support is Needed
- [ ] Other Describe Below

**More Information:**

---

Revised 5-2018
CHILD STUDY CENTER

APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name ________________________________ Patient Date of Birth _______________

CHILD TRAUMA HISTORY

HAS THE CHILD EXPERIENCED A TRAUMATIC EVENT?  [ ] NO  [ ] SUSPECTED

[ ] YES, CONFIRMED  IF "YES" PLEASE CHECK ALL THAT APPLY

- PHYSICAL ABUSE
- SEXUAL ABUSE
- NEGLECT
- PSYCHOLOGICAL / EMOTIONAL ABUSE
- WEATHER DISASTER
- WITNESSED INTIMATE PARTNER VIOLENCE (IPV) / DOMESTIC VIOLENCE (DV)
- OTHER - DESCRIBE BELOW
- ACCIDENT
- COMMUNITY VIOLENCE
- MEDICAL PROCEDURE / ILLNESS
- SCHOOL VIOLENCE
- WAR / TERRORISM

More Information:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
PREGNANCY AND BIRTH HISTORY

WAS THIS CHILD’S PREGNANCY EXPECTED? □ YES □ NO

MOTHER’S AGE AT PREGNANCY

WERE THERE FERTILITY PROBLEMS? □ YES □ NO

NUMBER OF PRIOR PREGNANCIES

NUMBER OF PRIOR MISCARRIAGES

NUMBER OF WEEKS PREGNANT WHEN PREGNANCY WAS DISCOVERED

DID THIS CHILD’S MOTHER USE ALCOHOL, TOBACCO, OR DRUGS DURING PREGNANCY, INCLUDING BEFORE THE PREGNANCY WAS KNOWN? IF YES, PLEASE CHECK ALL THAT APPLY

□ ALCOHOL □ TOBACCO □ RECREATIONAL DRUGS □ PRESCRIPTION MEDICATIONS

LIST ALL RECREATIONAL AND PRESCRIPTION DRUGS TAKEN DURING PREGNANCY:

COMPLICATIONS DURING PREGNANCY □ YES □ NO IF YES, DESCRIBE ____________________________

DID THIS CHILD’S MOTHER NEED TO VISIT THE EMERGENCY ROOM DURING PREGNANCY □ YES □ NO IF YES, DESCRIBE ____________________________

NUMBER OF WEEKS AT DELIVERY ____________ BIRTH WEIGHT: POUNDS ____________ OUNCES ________

COMPLICATIONS OF DELIVERY □ LONG LABOR □ INFECTION □ NICU

□ TROUBLE BREATHING/RESPIRATORY DISTRESS □ OTHER

DELIVERY DETAILS □ NORMAL VAGINAL BIRTH □ FORCEPS □ VACUUM ASSIST

□ CESAREAN SECTION □ BREECH BIRTH

More Information:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### CLINICS WITHIN THE SECTION OF DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

Check this list to ensure the type of service you are needing is available and indicate which clinic you feel would best serve the needs of the child. (Helpful if you know, but not required for processing).

*For clinics that are currently unavailable, please check back at a later date. We are working on getting these re-opened.*

<table>
<thead>
<tr>
<th>Clinic Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A BETTER CHANCE CLINIC (ABC)</td>
<td>Assessments for patients, birth to age 7, for <strong>CONFIRMED EXPOSURE</strong> to drugs and/or alcohol before birth. Includes comprehensive developmental evaluations, behavior management programs, information, coordination with other programs and agencies, and guidance/support to families and caregivers who are raising infants/children considered to be high-risk.</td>
</tr>
<tr>
<td>ADHD AND DEVELOPMENTAL-BEHAVIORAL PEDIATRIC CLINIC</td>
<td>Medical evaluations and treatment as needed including medication management for patients, age birth to 18 years, with complex neurodevelopmental disorders including ADHD and other disruptive behavior disorders, autism spectrum disorders, language disorders, and intellectual disability, among others.</td>
</tr>
<tr>
<td>BEHAVIOR CLINIC AND PARENT CHILD INTERACTION THERAPY (PCIT)</td>
<td>Assessment and treatment services for children and adolescents with a wide variety of emotional and behavioral problems.</td>
</tr>
<tr>
<td>CHILD GUIDANCE SERVICES</td>
<td>Developmental and Autism screenings, speech/language/hearing assessments, and behavioral consultation, evaluation, and therapy, parenting classes, support groups, and individual consultation, child care mental health consultation, resources, and referral services.</td>
</tr>
<tr>
<td>CHILD TRAUMA SERVICES (CTS)</td>
<td>Assessment and treatment, age 3 and up, and families impacted by trauma. Includes child trauma assessment and Trauma-Focused Cognitive -Behavioral Therapy (TF-CBT).</td>
</tr>
<tr>
<td>DEVELOPMENTAL DELAY AND PSYCHOEDUCATIONAL EVALUATION CLINIC</td>
<td>Evaluations age 6 to 18 with concerns regarding developmental delays, behavior, and academic achievement.</td>
</tr>
<tr>
<td>JUMPSTART / AUTISM EVALUATION CLINIC</td>
<td>Evaluations for children age 6 years 11 months old and younger with suspected autism spectrum disorders.</td>
</tr>
<tr>
<td>OCCUPATIONAL THERAPY EVALUATION</td>
<td>Assessments for birth to 18 years for fine/gross motor development, pre-writing/writing skills, visual motor skills, self-care daily tasks, sensory integration, and social skills.</td>
</tr>
<tr>
<td>PEDIATRIC NEUROPSYCHOLOGY CLINIC</td>
<td>Comprehensive neuropsychological evaluations for patients age 2 to 18 with medical, neurological, and/or neurodevelopmental disorders.</td>
</tr>
<tr>
<td>PROBLEMATIC SEXUAL BEHAVIOR PROGRAM</td>
<td>Outpatient clinical program for children age 3-12 who are exhibiting problematic sexual behavior &amp; for boys age 13-18 with illegal sexual behavior.</td>
</tr>
<tr>
<td>SPECIALIZED ASSESSMENT CLINIC</td>
<td>Psychological evaluations for children ages 5 and older for a variety of problems such as Autism, ADHD, Emotional/Behavioral disturbances, and learning disabilities. Clinic also provides outpatient Cognitive Behavior Therapy services. This is NOT a medical evaluation.</td>
</tr>
</tbody>
</table>