Developmental and Behavioral Pediatrics
Koppel Plaza, 2100 Clinch Avenue, Suite 410
Knoxville, TN 37916
Phone (865) 343-6976
Fax (877) 926-0521

Scheduling Process

Your child has been referred to our center for an evaluation. We look forward to serving your family. The following steps will guide you through the scheduling process and provide instructions on how to prepare for your appointment.

Scheduling process

1) Have your child's primary care physician complete a request form.

2) Check with your insurance regarding coverage. Your insurance may require a specific referral from your child's primary care physician (this is different than the physician request attached to this packet). This type of visit may be classified as behavioral, depending on your insurance, and different deductibles may apply. The consultation fee code (99245) is $546 +any additional screenings deemed necessary.

   However, we will bill this to insurance on your behalf you will be responsible for any applicable copay or percentage which is expected at the time of service.

3) Complete the registration questionnaire as completely as possible. We use this information to schedule the most appropriate appointment for your child. Please complete in blue or black ink only.

4) Return forms by:

   - fax (877) 926-0521

   - US mail or in person:
     East Tennessee Children's Hospital
     Developmental and Behavioral Pediatrics
     Koppel Plaza, 2100 Clinch Avenue, Suite 410
     Knoxville, TN 37916

5. Once we receive your referral form and registration questionnaire, we will contact you to schedule your child's appointment or ask other questions. If you have not been contacted within 4 weeks, please contact us as we have been trying to reach you. **An appointment will not be scheduled until we receive your forms.**

6. Our no show/late policy is included. **Missed initial visit appointments will not be rescheduled but will be charged the full amount of the consult (546).**

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Preparing for Your Appointment

As you may be aware, there is no specific test for Developmental and Behavioral Pediatrics issues such as ADHD, Anxiety, Autism, etc. This is a specialty pediatric practice and your child will receive a complete head to toe physical like he/she would at their annual checkup with particular attention to neurological and mental health exam. The entire visit can last up to 2 hours.

- It is important that both parents be present at the appointment.
- Arrange childcare for siblings. Other children maybe disruptive to the initial evaluation.
- During the visit we will spend time with the child and the parents separately.
- Discuss the visit with your child. We do not want them to be surprised. Say things like "we are going for a check up about how you are doing in school" or "we are going for a check up about how much you worry." The discussion does not need to be long but should be truthful.
- Your child does need to attend the appointment.
- **The more information we obtain the better assessment we can make.**

Bring to the office consultation visit:

- Guardianship/custody papers if both biological parents will not be present
- Insurance card(s)
- Baby book
- Report Card(s)
- Examples of school work
- Standardized testing results (TCAPs, achievement test)
- Note or attached form from teacher about any school concerns
- Communication (note or email) from a parent who is unable to attend the visit
- Evaluations performed elsewhere (such as Speech-Language, Physical or Occupational Therapy, Neurology, Genetics, etc.)
- Note from therapist, counselor or tutor
- Any additional information that you feel would be helpful for your child's evaluation
- An activity or game to occupy your child during the "parent only" portion of the visit

EAST TENNESSEE Children's Hospital

Regional Practices

Patient Information

Patient Primary Care Physician: _____

Last name: _____ First: _____ Mid: _____

D.O.B.: ___ /___ /_____ Sex: ☐ Male ☐ Female SSN: _____-_____-_____

Siblings:_____

Address Line 1: _____ Primary phone: ☐ Home ☐ Cell

Address Line 2: _____ Home phone: (____)_____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____)_____ - _____

Mother/legal guardian **Relation:** _____

Last name: _____ First: _____ Mid: _____

D.O.B.: ___ /___ /_____ Sex: ☐ Male ☐ Female SSN: _____-_____-_____ Email: _____

Address Line 1: _____ Primary phone: ☐ Home ☐ Cell

Address Line 2: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Employer: _____ Ok to leave message: ☐ Y / ☐ N

Address: _____ Marital status: _____

City:_____ State: _____ ZIP: _____ Work phone: (____) _____ - _____

Father/legal guardian **Relation:** _____

Last name: _____ First: _____ Mid: _____

D.O.B.: ___ /___ /_____ Sex: ☐ Male ☐ Female SSN: _____-_____-_____ Email: _____

Address Line 1: _____ Primary phone: ☐ Home ☐ Cell

Address Line 2: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Employer: _____ Ok to leave message: ☐ Y / ☐ N

Address: _____ Marital status: _____

City:_____ State: _____ ZIP: _____ Work phone: (____) _____ - _____

Emergency contact *(other than parent or legal guardian)* Relation: _____

Last name: _____ First: _____ Mid: _____

Address: _____ Home phone: (____) _____ - _____

City:_____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Patient

Race: ☐ American indian/Alaska native ☐ Asian ☐ Black or African american ☐ Hispanic ☐ White ☐ Other

Ethnicity: ☐ Non-hispanic ☐ Hispanic/Latino ☐ Refused to report

Preferred language for healthcare discussion: ☐ English ☐ Spanish ☐ Other_____

Insurance information *(primary)*

Insured's last name: _____ First: _____ MI: ____

Relationship to patient:_____ D.O.B.: ___ /___ /_____ SSN:_____-____-_____

Insured address:_____ Phone: (____)_____ - _____

City:_____ State: _____ ZIP: _____

Insurance name:_____ Effective date: ___ /___ /_____

Employer name:_____

Insurance information *(secondary)*

Insured's last name: _____ First: _____ MI: ____

Relationship to patient:_____ D.O.B.: ___ /___ /_____ SSN:_____-____-_____

İnsured address:_____Phone: (____)_____ - _____

City:_____ State: _____ Zip: _____

Insurance name:_____ Effective date: ___ /___ /_____

Employer name:_____

Pharmacy

1) Name: _____ Phone: (____)_____ - _____

Address: _____

2) Name: _____ Phone: (____)_____ - _____

Address: _____

Preferred communications

Phone call: ☐

Text messaging: ☐

Preferred phone: (____)_____ - _____

Preferred language: ☐ English ☐ Spanish

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

Send reminder/Follow-up letters: ☐

Send reminder/Follow-up emails: ☐

Type of reminders/Follow-up:

Select all ☐

Appointments ☐

Lab results ☐

Health maintenance ☐

Rx confirmation ☐

General notification ☐

I give consent for the individuals listed on this form to bring the patient to East Tennessee Children's Hospital for treatment of illnesses or injuries. I hereby give permission to East Tennessee Children's Hospital to exchange information with the individuals listed on this form.

_____ _____ _____

Parent/legal guardian signature Relationship Date

Why does your child need to be evaluated in our center? _____

_____

_____

_____

Has your child been seen by our office previously? ☐ Yes ☐ No

Check box any conditions you are concerned your child may have:

☐ Anger Management Issues
☐ Anorexia
☐ Anxiety
☐ Attention Deficit Disorder
☐ Autism
☐ Bedwetting
☐ Bulemia
☐ Depression
☐ Developmental Delay
☐ Dyscalculia (Math Problems)
☐ Dyslexia (Reading problems)
☐ Gender Identity Issues
☐ Issues with Sexual Behavior
☐ Mood Disorder
☐ Obsessive-Compulsive Disorder
☐ Oppositional Defiant Behavior
☐ Panic Attacks
☐ School Avoidance
☐ Sleep Problems
☐ Speech Delay
☐ Suicidal Thoughts
☐ Tic/Tourette's Syndrome
☐ Other:_____

Who lives in the home with the child?

_____

List siblings names and their ages:

_____

Adoptive/foster families: is your child aware of the adoption? ☐ Yes ☐ No ☐ N/A

Have any siblings seen any providers in our office? ☐ Dr. Christiansen ☐ Mrs. Atkins ☐ Mrs. Polk List siblings name: _____ _____

What school does your child attend?_____

In what grade is your child?_____

Who referred your child to our center? _____

Other providers that treat your child

Who is your child's primary care physician? _____

Who are the other doctors your child has seen? Why?: _____

_____

_____

Tutor's name:_____

Counselor/ Psychologist Name: _____

Speech Pathologist Name: _____

Occupational Therapist Name: _____

Physical Therapist Name: _____

Has your child had any testing for these concerns? ☐ Yes ☐ No

Has your child ever seen a geneticist or had chromosome testing? _____

Previous diagnostic testing for any developmental-behavioral concerns _____

_____

_____

_____

Please bring a copy of the testing/evaluation with you to the appointment.

Does your child have an S-team? ☐ Yes ☐ No

Does your child have an IEP? ☐ Yes ☐ No

Does your child have an 504? ☐ Yes ☐ No

List any extra help your child receives at school. _____

_____

_____

Current behavior medication: _____

Behavioral medications taken in the past and reason for discontinuing _____

_____

_____

_____

List any significant change or loss that your child has experienced such as divorce, death, or move.

_____

_____

_____

Answer the following questions and discuss any "yes" answers below.

☐ Yes ☐ No Is there trouble going to sleep?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Is there trouble staying asleep?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Is there a problem with bedwetting?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Is there a problem with encopresis (uncontrollable bowel movements)?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Does your child have a poor appetite or poor diet?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Are there any nervous habits (nail biting, hair pulling)?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Are there any significant worries or fears (storms, germs).
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Have there been any panic attacks?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Are there any obsessive/compulsive behaviors?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Does your child have any autistic behaviors?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Does your child have flapping of the arms when excited?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Does your child have any scripting (repeats specific lines or phrases)?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Is your child unusually fixated on any specific item?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Does your child have echolalia (repeat over what someone else says)?
Please explain any "yes" answers: _____
_____

☐ Yes ☐ No Does your child have a depressed mood?
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Does your child have a problem with regulating mood (happy to angry to sad)?
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Is there difficulty with anger control? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child had any auditory hallucinations? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child had any visual hallucinations?
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child had a suicide attempt?
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child made any suicide threats?
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child had any self-harm behaviors like cutting? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Is your child aggressive or unusually cruel to animals?_____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Is your child aggressive or unusually cruel to other children?
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Does your child have an issue with excessive masturbation?
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Does your child use sexually inappropriate language? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child been sexually abused? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child been sexually abusive to another child? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child had any sexually inappropriate touching? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child witnessed any abuse? _____
Please explain any "yes" answers: _____
_____
_____

☐ Yes ☐ No Has your child been physically abused? _____
Please explain any "yes" answers: _____
_____
_____

What difficulties occur at home? _____
_____

What academic problems does the child have in school? _____
_____
_____

What behavior problems occur at school? _____
_____
_____

Discuss any other concerns that you have that might help us to schedule the most appropriate appointment for your child.
_____
_____
_____
_____
_____
_____

We will use this information to get your child an appropriate appointment.
Please complete all forms as accurately and concisely as possible.

Do either side of the child's immediate biological family have any of the following?
Please explain any yes answers?

☐ Yes ☐ No **ADHD** Please explain any "yes" answers _____

☐ Yes ☐ No **Learning Disabilities** Please explain any "yes" answers _____

☐ Yes ☐ No **Autism/Asperger's** Please explain any "yes" answers _____

☐ Yes ☐ No **Depression** Please explain any "yes" answers _____

☐ Yes ☐ No **Anxiety/OCD** Please explain any "yes" answers _____

☐ Yes ☐ No **Bipolar** Please explain any "yes" answers _____

☐ Yes ☐ No **Schizophrenia** Please explain any "yes" answers _____

☐ Yes ☐ No **Suicide or Suicide attempts** Please explain any "yes" answers _____

☐ Yes ☐ No **Alcohol/Drug Abuse** Please explain any "yes" answers _____

☐ Yes ☐ No **Incarceration** Please explain any "yes" answers _____

☐ Yes ☐ No **Tic Disorder** Please explain any "yes" answers _____

☐ Yes ☐ No **Sleep Disturbance** Please explain any "yes" answers _____

☐ Yes ☐ No **Thyroid Disease** Please explain any "yes" answers _____

☐ Yes ☐ No **Heart Disease** Please explain any "yes" answers _____

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Teacher Information

Please rank this student compared to the other students in his/her classroom.

Reading ability	Upper Third	Middle Third	Lower Third
Math ability	Upper Third	Middle Third	Lower Third
Handwriting	Upper Third	Middle Third	Lower Third
Work Habits	Upper Third	Middle Third	Lower Third
Homework Grades	Upper Third	Middle Third	Lower Third
"Actual Grades"	Upper Third	Middle Third	Lower Third
Behavior Grades	Upper Third	Middle Third	Lower Third
Peer to Peer relationships	Upper Third	Middle Third	Lower Third
Focus/Attention for listening	Upper Third	Middle Third	Lower Third
Focus/Attention for classwork	Upper Third	Middle Third	Lower Third

Do you think this student was "on grade level"/ready for your class at the beginning of this school term?_____

_____

What do you personally see as the biggest struggle for this student? _____

_____

What strategies have you tried that have been successful/unsuccessful? _____

_____

Do you see any difficulty with anxiety or mood? Please expand if so. _____

_____

What do you personally see as the biggest strength for this student? _____

_____

Do you have any other concerns about this student? _____

_____

Any additional Comments are welcomed as we all attempt to help your student. _____

_____

_____

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

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

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

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No Show Policy/ Late Policy

We strive to provide the best possible care for all patients. A missed appointment prevents your child and another patient from receiving help.

If you fail to notify our office that you are not going to be able to keep a scheduled appointment within 24 hours, you will be charged for that appointment. Repeated missed appointments may result in dismissal from the practice.

The full consultation fee ($455) will be charged for a missed consultation (first) appointment. This appointment will not be rescheduled.

For follow-up visits, there is a $100 charge for failure to notify our office. This may result in delays in your child receiving prescription.

We do endeavor to give each family timely care and attention. We do schedule to minimize waiting times. In an attempt to prevent delays for other patients, you may be asked to reschedule if you arrive more than 15 minutes late.

Child's name:_____

I acknowledge that I am aware of the No Show/Late Policy.

Signature: _____ Date:_____

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Physician Request

I am referring _____ to the Developmental and Behavioral Pediatrics for a consultation.

Name:_____ D.O.B.: _____

_____
(Primary Care Provider Signature) (Date)

Please print Primary Care Provider full name: _____

Office address: _____

_____
(fax #)

☐ I would like to receive copy of this consultation.

☐ Insurance referral included
☐ Insurance referral not needed

Are there any specific concerns we should address? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____