

CENTER FOR CHILDREN WITH SPECIAL NEEDS
Children's Hospital at Providence
2401 E 42nd Ste 306, Anchorage AK 99508
Telephone: 562-9212 Fax: 562-2409

Please complete and return all the enclosed pages. Our clinic is one of many community providers using the *Iditaform* as part of our intake questionnaire. The *Iditaform* provides a complete history of health & development of your child. We encourage you to keep a copy of the *Iditaform* for your records (we will be happy to make you a copy if needed). If you already are using the *Iditaform* please add new/current information and send us a copy of your existing form. In addition, please complete and return pages A-E.

Your information will be confidential and will only be used by the team evaluating your child at this clinic. If you need more space, please feel free to attach extra sheets of paper. If you have any questions about this packet or need additional information please contact us.

PATIENT NAME _____ DATE OF BIRTH _____

Describe the concerns which lead to this evaluation: _____

PRIMARY PHYSICIAN:

Name _____

Pediatric _____ Family Practice _____ Other (please specify) _____

Is your physician aware of this evaluation? ___yes ___no (if no please explain) _____

REFERRED BY:

Name _____ Address _____

Reason for referral: _____

Name of person(s) completing this form _____

Relationship to child _____

(Title of professional) _____

Date _____

PATIENT NAME _____ DATE OF BIRTH _____

PARENT/GUARDIAN CONCERNS

What are your concerns about your child? _____

AREAS OF CONCERN (check boxes that apply)

Comments

- Physical health
- Hearing
- Vision
- Growth: ___overweight ___underweight
- Height: ___short ___tall
- Diet and/or feedings
- Sleeping
- Elimination
- Coordination and/or motor skills
- Development of self-help skills
- Speech language
- School achievement or learning
- Behavior
- Discipline
- Emotional adjustment

Has your child had prior evaluations for these concerns? ___no ___yes (if yes):

By whom? _____ When _____

Describe briefly: _____

Did you agree with the results? ___yes ___no

Were you able to obtain recommended services? ___yes ___no

Please comment: _____

AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

Please send reports to: CENTER FOR CHILDREN WITH SPECIAL NEEDS
Children's Hospital at Providence
2401 E 42nd Ave., Ste 306
Anchorage AK 99508-5228

Phone: (907) 562-9212
Fax: (907) 562-2409

PATIENT NAME _____ DATE OF BIRTH _____

The purpose of obtaining/releasing information is to get a complete record of medical and developmental history. This information is essential to providing a comprehensive evaluation and to recommending appropriate services as well as to avoid unnecessary testing and duplication.

The following people have been, or will be involved with my child's care. I authorize mutual exchange of information between the CENTER FOR CHILDREN WITH SPECIAL NEEDS, Children's Hospital at Providence and:

<u>Please check all that apply</u>	<u>Please print name & phone number of provider</u>	<u>Office use only</u> <u>Req. / Rec.</u>
<input type="checkbox"/> Primary Physician	_____	_____
<input type="checkbox"/> Eye exams	_____	_____
<input type="checkbox"/> Hearing test	_____	_____
<input type="checkbox"/> Hospital Records	_____	_____
<input type="checkbox"/> Lab, MRI, CT scan, EEG	_____	_____
<input type="checkbox"/> Infant Learning Program	_____	_____
<input type="checkbox"/> School Records	_____	_____
<input type="checkbox"/> Psychology / Counseling	_____	_____
<input type="checkbox"/> Speech Therapy	_____	_____
<input type="checkbox"/> Physical Therapy	_____	_____
<input type="checkbox"/> Occupational Therapy	_____	_____
<input type="checkbox"/> ARCA	_____	_____
<input type="checkbox"/> Other (please list)	_____	_____
<input type="checkbox"/> Other (please list)	_____	_____
<input type="checkbox"/> Other (please list)	_____	_____
<input type="checkbox"/> Other (please list)	_____	_____
<input type="checkbox"/> Other (please list)	_____	_____
<input type="checkbox"/> Other (please list)	_____	_____

I understand that this information will be kept in my child's file and will not be released without my permission. All practices of confidentiality will be followed in the use of the information gathered. This release is valid for twelve months after date signed. I have had an opportunity to ask questions and have my questions answered.

Signature

Relationship to child

Date

Please print name

Address

PATIENT INFORMATION

Patient name _____ SS# _____
Last First MI
Mailing Address _____
City State ZIP
Home Phone _____ Race _____ Sex _____
Birth Date _____ Resides with Mother Father Both Other _____
Mother's Name _____ Father's Name _____

RESPONSIBLE PARTY (Parents or Guardians)

Name _____ Relationship to Patient _____
Address _____
Home Phone _____ Work phone _____
Employer _____ Occupation _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Address _____
Home Phone _____ Work phone _____

BILLING INFORMATION

Self pay? Yes No
Are you eligible for Alaska Native benefits (IHS)? Yes No

Primary Insurance

Name _____
Mailing address _____
Subscriber Name (Insured person) _____ Sex _____
Subscriber number _____ Group number _____
Subscriber Employer _____ Employment status Full Part Self Retired
Social Security Number _____ Subscriber date of birth _____

Secondary Insurance

Name _____
Mailing address _____
Subscriber Name (Insured person) _____ Sex _____
Subscriber number _____ Group number _____
Subscriber Employer _____ Employment status Full Part Self Retired
Social Security Number _____ Subscriber date of birth _____

CENTER FOR CHILDREN WITH SPECIAL NEEDS
Children's Hospital at Providence
2401 E 42nd Ste 306, Anchorage AK 99508
Telephone: 562-9212 Fax: 562-2409

PATIENT NAME _____ DATE OF BIRTH _____

Please send report to:

Parents _____
Address _____
Phone _____

Physician _____
Address _____
Phone _____

School _____
Address _____
Phone _____

Other _____
Address _____
Phone _____

Other _____
Address _____
Phone _____

Other _____
Address _____
Phone _____

Other _____
Address _____
Phone _____

Signature of Parent or Guardian

Date