Behavioral and Developmental Referral Center

Baylor College of Medicine

Texas Children's Hospital®

The Meyer Center for Developmental Pediatrics **Psychiatry Service** **Psychology Service**

Dear Parent,

Thank you for allowing us the opportunity to serve your family. We will make every effort to best meet your needs.

You will find a brief questionnaire enclosed with this letter. This information will help us decide how to best help your child, either here at Texas Children's Hospital or in the community. Please complete this form and return it to our office at your earliest convenience using the fax number or mailing address provided below. **Please allow us ten business days to review your information and make a decision about scheduling for your child**.

It is possible that the services provided within the Behavioral and Developmental Sciences at Texas Children's Hospital may not best serve needs of your child. If this is the case, the Behavioral and Developmental Referral Center will provide you with alternate resources to help you find the most appropriate services for your child.

If we are able to provide the services you seek, you will be asked to fill out a second form, a more comprehensive history form, *prior* to scheduling an appointment. Our office will call you within 10 business days of the receipt of this completed intake form to inform you of when the history form will be mailed out and clarify the next steps toward scheduling. Once this history form is completed and returned to Behavioral and Developmental Sciences, you will then be contacted to schedule an appointment.

Mail: Texas Children's Hospital
Behavioral and Developmental Referral Center
6701 Fannin Street, CC1630.00
Houston, TX 77030

Fax: 832-825-9315

Phone: 832-822-1900

Thank you again for your time and effort. You know your child better than anyone else and the information you provide is extremely valuable to us. If you have any questions regarding our procedures or need further help, please call us.

Sincerely,

Behavioral and Developmental Sciences at
Texas Children's Hospital

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If you are a PCP or other Referring Provider, please fill out this box.

Provider Name_____ **Phone #**_____

Fax #_____

☐ **TCH Physician** ☐ **TCPA Physician** ☐ **Other Provider**

What is the referral question?_____

_____

_____

Are you requesting that a specific provider see this patient?_____

If you would like to share or convey additional information please call 832-822-1900

Parent/Caregiver:

Please complete the remainder of this form to the best of your knowledge. If questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

PATIENT INFORMATION (PLEASE PRINT)				
Last Name	First Name & MI	Age	Date of Birth	M / F

CURRENT CONCERNS:

Please tell us about your <u>MAIN</u> concerns:

_____

_____

_____

Has your doctor requested that your child see a specific doctor/provider? ☐No ☐ Yes: _____

To help us understand your concerns, please check any boxes that apply.

☐ **My child has unusual behaviors:**
- ☐ repeats the same behavior over and over
- ☐ plays with toys in unusual ways (lines things up, counts them)
- ☐ gets stuck on certain activities/topics
- ☐ is especially sensitive to the sight, feel, sound, taste, or smell of things
- ☐ flaps his/her hands
- ☐ is interested in unusual things (paper clips, bottle caps, stop signs, string)
- ☐ has trouble with change or transitions
- ☐ repeats lines from movies, TV, etc.
- ☐ uses your hand to show wants and needs
- ☐ has odd movements or tics

☐ **My child has social difficulties:**
- ☐ is teased or bullied
- ☐ prefers to be alone
- ☐ is not interested in having friends
- ☐ is mean to other children
- ☐ has poor eye contact

☐ **I have concerns about my child's development:**
- ☐ language delays or regression
- ☐ motor delays or regression
- ☐ toileting problems
- ☐ problems with feeding

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☐ **My child has trouble with attention:**
- ☐ has trouble concentrating or focusing
- ☐ has a short attention span
- ☐ is very distractible

☐ **I have concerns about my child's mood:**
- ☐ seems depressed or unhappy
- ☐ seems too irritable
- ☐ has sleep or appetite changes
- ☐ is moody or has mood swings
- ☐ has extreme happiness

☐ **My child seems anxious or nervous:**
- ☐ is too shy
- ☐ is repeatedly bothered by upsetting thoughts (germs, illness, horrible events, "bad" thoughts, etc.)
- ☐ feels driven to do things over and over (wash, check, count, confess, arrange, even, collect, etc.)
- ☐ is too anxious in social situations
- ☐ has frequent nightmares
- ☐ seems to worry too much
- ☐ has trouble separating from parents/loved ones
- ☐ has unusual fears or phobias

☐ **My child has problems thinking:**
- ☐ has unusual beliefs that cannot be true
- ☐ hears or sees things that are not there
- ☐ feels like others are out to get him/her

☐ **My child has behavior problems:**
- ☐ is easily frustrated
- ☐ acts impulsively
- ☐ is overly active
- ☐ is aggressive
- ☐ has been suspended/expelled from school
- ☐ does not obey
- ☐ breaks rules
- ☐ is in legal trouble
- ☐ uses drugs or alcohol
- ☐ is overly focused on weight loss
- ☐ diets or exercises too much
- ☐ uses vomiting or other things to get rid of food he/she has eaten

☐ **My child has trouble learning/at school:**
- ☐ with letter identification or reading
- ☐ with spelling or writing
- ☐ with math
- ☐ with memory

CARE OF MY CHILD:

☐ **My child has had psychological or educational testing through school or another agency**
☐ No ☐ Yes, **If yes, please submit all copies of prior testing with this referral form**

Has your child ever participated in any of the following programs?

- ☐ Gifted and Talented
- ☐ Advanced Academic Curriculum
- ☐ Special Education/IEP
- ☐ Section 504 services
- ☐ Content Mastery
- ☐ Resource Room Services
- ☐ Alternative Academics
- ☐ Self-Contained Class
- ☐ Life Skills Class
- ☐ Behavioral/Emotional Disorders Class
- ☐ Speech & Language Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Adaptive Physical Education
- ☐ Counseling (school based)
- ☐ Alternative School Placement
- ☐ Early Childhood Intervention (ECI)
- ☐ PPCD
- ☐ Other:_____

☐ **My child sees a doctor at Texas Children's Hospital:** ***If yes, when, who and why?***

_____

_____

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☐ **My child sees a mental health provider (Psychiatrist, Psychologist, Social Worker, Therapist, Counselor):**
If yes, when, who and why?

_____

_____

☐ **My child has been hospitalized for psychiatric concerns:** ***If yes, when, where and why?***

_____

_____

_____

☐ **Does your child have a diagnosis of any psychological, psychiatry condition?**

_____

_____

☐ **Does your child have a serious medical condition?**

_____

_____

☐ **Are there currently any major stressors affecting your family or your child (e.g. deaths, job change, school change, physical or sexual abuse, separation or divorce, use of drugs or alcohol in the family)?**

_____

_____

What services are you seeking to receive from us (check all that apply)?

☐ **Assessment/Testing/Evaluation**
- ☐ for ADHD or ADD
- ☐ for Autism, Asperger's, or PDD
- ☐ for problems with development
- ☐ for depression
- ☐ for bipolar disorder
- ☐ for anxiety
- ☐ neuropsychological testing
- ☐ for help with figuring out diagnosis
- ☐ other: _____

☐ **Treatment/Intervention**
- ☐ medication management
- ☐ individual or family therapy
- ☐ parenting/behavior management
- ☐ help with sleeping, feeding, or potty training
- ☐ adherence to treatment
- ☐ pill swallowing
- ☐ other: _____

Does your child take medications?

	now	past		now	past
attention	☐	☐	aggression	☐	☐
depression	☐	☐	behavior problems	☐	☐
anxiety	☐	☐	sleep	☐	☐
mood	☐	☐	tics	☐	☐

Please list all current medications (with dosages):

_____

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DEMOGRAPHIC INFORMATION:

PATIENT INFORMATION (PLEASE PRINT)				
Last Name	First Name & MI	Age	Date of Birth	M/F
Street Address	City	State	Zip Code	
Primary language of the child: _____ Primary language of the parent(s): _____				
Translator needed? If Yes, what language? Yes _____No _____ / Language: _____				
Parent/Guardian(s) Name(s):				
Contact Phone Numbers	Home	Cell	Work	
REFERRING PHYSICIAN INFORMATION	**Is this your Primary Care Physician?** ☐ Yes ☐ No			
Referring Physician Name (PCP and/or Sub specialist)				
Practice Contact	Office Phone	Office Fax		
INSURANCE INFORMATION: ***(If possible please provide a copy of insurance card front and back.)***				
What insurance plan do you have?				
Name of Company				
Plan #	Group #			
Phone number for customer service				
Mental Health/Substance Abuse phone number, if different from primary insurance number				
Card holder's information Name				
Gender: ☐ Male ☐ Female	Date of Birth:			
Social Security #	Name of Employer:			
If Medicaid Program name of program				
Medicaid #				

Name of the person filling out form:_____

Relationship to child (Parent, Grandparent, Guardian etc.) _____

Date:_____

Please return this form by fax, or mail:

Fax: 832-825-9315

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