UC San Diego SCHOOL OF MEDICINE

THE DEVELOPMENTAL-BEHAVIORAL PEDIATRICS CLINIC

7910 Frost Street, Suite 280 San Diego, California 92123

UC San Diego SCHOOL OF MEDICINE

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Dear Parent/Caregiver:

The following steps outline the process to obtain an appointment and help prepare for your visit to UCSD Developmental-Behavioral Pediatrics.

❶ **Primary Care Physician (PCP) or referring provider faxes a referral to 858-496-9257.**
The form is included in this packet for you to give to your PCP to complete, however check with your PCP to see if they have already started the referral process. The referral form from your PCP must include the patient's diagnosis code(s).

❷ **Insurance Authorization** –For an appointment to be scheduled for your consultation, we must have authorization from your insurance or your agreement to self-pay. You will be responsible for any co-pay, deductible or self-payment at the time of your visit.

❸ **Scheduling** – Our staff will contact you to schedule your visit.

❹**Child Registration Form** and **Questionnaires**
Ask your child's teacher (or teachers, if they have multiple teachers) to complete the **School Questionnaire**. If your child is not in school, a babysitter, daycare provider, camp counselor, tutor, behavior or developmental therapist (speech, occupational, physical) etc. may fill out the school questionnaire instead. **Parents must complete the new patient forms within two weeks of scheduling your appointment.**

❺**All questionnaires must be complete and received by the Developmental Behavioral Pediatrics office within 2 weeks of scheduling your appointment to avoid cancellation or rescheduling.**
COMPLETED forms may be sent to Developmental-Behavioral Pediatrics in one of 4 ways:

Via U.S. Mail: **UCSD Developmental Behavioral Pediatrics**
7910 Frost St.
Suite 280
San Diego, CA 92123

Via Fax: **(858) 496-9257**

Drop Off at The Clinic: **UCSD Developmental Behavioral Pediatrics**
Same address as above

Upload via My Chart: https://mychartatradychildrens.org
Please initiate an advice question to the provider your child is scheduled to see.
The document can then be attached.

❻ You may provide **additional documentation** that you feel would be helpful for your child's evaluation, such as:

- School documents, such as IEPs and School Assessments
- Evaluations done at other medical facilities (e.g., neurology, genetics, etc.)
- Evaluations done at nonmedical facilities such as California Early Start, Regional Center, First 5
- Lab tests or imaging studies done outside of Rady Children's Hospital
- Therapist/Counselor Notes or a letter from the therapist/counselor, if your child has seen one.

Please call (858) 496-4860 if you have any questions

We look forward to serving your family!

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Developmental-Behavioral Pediatrics Clinic

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Consultation Request Form **Fax completed form and supplemental information to 858-496-9257**

Patient Information:

Child's Name:_____ Date of Birth: / / Age: Gender: ☐ M ☐ F ☐Other

Caregiver's Name:_____

Relation: ☐ Parent ☐ Foster Parent ☐ Other:_____

Will an interpreter be needed? ☐ No ☐ Yes Which Language? _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Home: ( ) _____ Alt: ( ) _____ Email: _____

In order to schedule an appointment, an insurance authorization must be in place. Please check if family plans to self-pay: _____ Authorization required: _____ YES _____ NO

Insurance Carrier/Type: _____

Subscriber Name: _____ Subscriber ID: _____

*Please have your staff request an authorization for **ALL** of the following CPT codes, a level 5 consultation visit (99245), developmental screening (96110), developmental testing (96112, 96113 X 3), behavioral assessment (96127 X 4), follow-up visits (99213 x4, 99214 x4, 99215 x4), prolonged service with direct patient contact (99354), and additional time (99417 x4).*

Referring Provider/Primary Care Physician:

Referring Provider Name: _____ Clinic Name: _____

Phone number: _____ Fax number for reports: _____

REQUIRED: Please describe in detail the primary reason for this consultation: _____

_____

_____

** For concerns of atypical development or learning problems, please ensure that referrals for appropriate concurrent services have also been submitted (e.g., school IEP request, speech therapy, etc.). **

Consultation requested for: ☐ diagnosis ☐ 2nd opinion ☐ medical workup ☐ medication management ☐ recommendations for services/resources

Diagnosis: ☐ Expressive language delay – F80.1 ☐ Receptive language delay or expressive and receptive language delay – F80.2 ☐ Gross motor delay – F82 ☐ Fine motor delay – F82 ☐ Social delay – F88 ☐ ADHD-inattentive – F90.0 ☐ Inattention R41.840 – Attention and concentration deficit ☐ Impulsiveness– R45.87 ☐ Hyperkinetic behavior – F90.9 ☐ ADHD-hyperactive/impulsive or combined type – F90.1 F90.2 ☐ Autism Spectrum Disorder – F84.0 ☐ Anxiety – F41.9 ☐ Depression – F32.9 ☐ Learning difficulties – F81.9 ☐ Academic underachievement – Z55.3 ☐ Oppositional behaviors/ODD – F91.3 ☐ Intellectual disability – F79 ☐ Feeding problems – R63.3 ☐ Sleep problems – G47.9

Is the patient currently under the care of a psychiatrist? ☐ Yes (If yes, please provide contact information and records) ☐ No

Other concerns with documented Dx code: _____

_____

_____

REQUIRED: Dx codes must be documented in EPIC referrals and on hard copy request.

***Note:** We do not evaluate children with complex or emergency mental health needs, or those taking multiple psychotropic medications. **Max age for new patients is 14 yrs. old.** We do not provide comprehensive psychological testing, ongoing behavioral therapy, or ongoing mental health counseling.*

_____ _____

Primary Care Physician's or Referring Provider's signature and specialty ***Date***

Developmental-Behavioral Pediatrics
Child Registration Form

Child's Name:	**Sex: M F Other:**	**Date of Birth:**
Child's Mailing Address:	City:	State/ZIP:
Home Phone, with area code: ( )	Child's Insurance:	
Child's Social Security Number:	Child's Race/Ethnicity:	

Child's Legal Guardian (please circle): Mother Father Both Other (specify):

Mother's Name:	**Date of Birth:**	**Home Phone: ( )**
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

Father's Name:	Date of Birth:	Home Phone: ( )
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

If there is another guardian other than the parents of this child, please complete guardian information below:

Guardian's Name:	Date of Birth:	Home Phone: ( )
Relationship to child:	Marital Status: S M W D Sep	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

PARENTS: Before we can evaluate your child, we need to collect information from your child's medical records, school, and other professionals involved in your child's care. We need your permission to do this. Please sign below.

MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Signature_____ Date_____

UC San Diego
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UCSD Developmental Behavioral Pediatrics

Dear Parents,

Effective January 3rd, 2022 we will be enforcing a fee for appointments not cancelled 48 hours in advance and missed appointments.

New patients will be charged $50.00 and returning patients will be charged $25.00.

_____

Parent/Guardian Signature

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Developmental-Behavioral Pediatrics
School Questionnaire

Parents please be sure to write your child's full name and date of birth at the top of each page of this questionnaire

Child's Name:_____Date of Birth: _____

Parent's Name: _____

The above-named child is being evaluated for attention, school, or behavior problems. As part of this comprehensive evaluation, we ask that you complete and return the following forms as soon as possible. **Please fill out the school-related forms detailed below and RETURN them promptly to the child's parents OR fax them directly to this child's doctor, DEVELOPMENTAL-BEHAVIORAL PEDIATRICS, at 858-496-9257.**

- School Questionnaire
- Teacher Questionnaire: Child Behavior
- Teacher Questionnaire: School Performance

If this child has more than one academic teacher, please make sure **two academic teachers** fill out the two Teacher Questionnaires (the school can copy the forms). **If this child is enrolled in summer school** have this child's summer school teacher complete the forms.

Please be as honest as possible in your responses. NOTE: Your comments are one part of a comprehensive evaluation; no diagnoses regarding this child will be made without input from several sources and without review by a trained clinician.

The parent / guardian of the above-named child has signed the following consent form that allows you to release the requested information.

> MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

_____
Parent Printed Name

_____ _____
Parent Signature Date

Thank you for your concern and commitment to helping this child.

School Questionnaire

Child's Name: **Date of Birth:** **Sex: M F Other** **Today's Date:**

Person(s) completing form: Title/Position:

The above named child has been referred for evaluation. Since a large part of the child's day is spent in school, a description of the child's behavior and school environment will be extremely useful in our assessment. The parent / guardian of this child has signed the following consent form that allows you to release the requested information.

MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Name of School:		School District:		
Teacher (primary):		Principal:		
School FAX:		School Phone:		
School Address:		City:	State:	Zip:
Child's Current Grade:	Months/Years at present school:	School Type (public, private, etc.):		
Indicate which school track this child is currently enrolled in: ____**Traditional** (Sept.-June) _____**Year-Round** _____**Summer School**				

CHIEF CONCERN

1. **How long** have teachers been concerned about this child?

2. What **concerns** do teachers have about this student?
   a.
   b.
   c.

3. Please describe this child's **strongest** areas in school:
   a.
   b.
   c.

4. Please describe this child's **weakest** areas in school:
   a.
   b.
   c.

HISTORY: School Intervention

Y	N	
Y	**N**	1. Has this child been in an **Early Intervention program**?
Y	**N**	2. Has this child had **speech, occupational or physical therapy**?
Y	**N**	3. Has this child **repeated a grade**? If Yes, which grade(s)?
Y	**N**	4. Has this child's **repeating a grade been discussed**? Specify:
Y	**N**	5. Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	**N**	6. Has this child received **any special education services**? Specify:
Y	**N**	7. Is this child **currently receiving any special education services**? Specify:
Y	**N**	8. Have any **disciplinary actions** been taken (suspension or expulsion)? Specify:

(OFFICE USE ONLY) concern **>6 months:** Y N **School Intervention:** Y N

HISTORY: School Problems Reported

For each of the following grades this child has completed, were any **problems reported**? If Yes, please **describe** the concerns in the space provided.

			Academics	Behavior
Y	**N**	Preschool		
Y	**N**	Kindergarten		
Y	**N**	First grade		
Y	**N**	Second grade		
Y	**N**	Third grade		
Y	**N**	Fourth and fifth grade		
Y	**N**	Sixth through eighth grade		
Y	**N**	High school		

History: Testing

Please list any Aptitude/Psychological or Achievement/Academic tests administered to this child (Please send copies of diagnostic testing results so that we do not duplicate testing).

Name of Test (no abbreviations, please)	Date Given	Grade/Year	Results
a.			
b.			
c.			
d.			

****Please attach any standardized testing, report cards, school study team summaries or IEP results available for this student.****

(OFFICE USE ONLY) **Academic School Performance:** Y N **Behavior School Performance:** Y N **Tests:** Y N

Child's Name: Date of Birth:

TEACHER QUESTIONNAIRE: Child Behavior (cont'd)

Check the box that best describes this child's behavior over the past 6 months. *If child is on medication, please rate child's behavior* ***NOT*** *on medication***.**	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
1. **Fails to give close attention** to details or **makes careless mistakes** in schoolwork.				
2. Has **difficulty sustaining attention** in tasks or activities.				
3. **Does not listen** when spoken to directly.				
4. **Does not follow through** on instructions and fails to finish schoolwork (not due to oppositionalbehavior or failure to understand).				
5. Has **difficulties organizing** tasks and activities.				
6. Avoids, dislikes, or is **reluctant to engage in tasks** that require sustained mental effort.				
7. **Loses things** necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by extraneous stimuli.				
9. Is **forgetful** in daily activities.				
10. **Fidgets** with hands or feet or squirms in seat.				
11. **Leaves seat** in classroom or in other situations in which remaining seated is expected.				
12. **Runs about or climbs excessively** in situations in which remaining seated is expected.				
13. Has **difficulty playing** or engaging in leisure activities quietly.				
14. Is **"on the go"** or acts as if "driven by a motor."				
15. **Talks excessively.**				
16. **Blurts out answers** before questions have been completed.				
17. Has **difficulty waiting in line**.				
18. **Interrupts** or intrudes on others (e.g. butts into conversations or games).				
19. **Loses** temper.				
20. Actively **defies or refuses** to comply with adult's request or rules.				
21. Is **angry or resentful**.				
22. Is **spiteful** and **vindictive.**				
23. **Bullies**, threatens, or scares others.				
24. **Initiates physical fights**.				
25. **Lies** to obtain goods for favors or to avoid obligations (i.e. "cons" others).				
26. Is **physically cruel** to people.				
27. Has **stolen items of nontrivial value.**				
28. Deliberately **destroys others' property.**				

(OFFICE USE ONLY) 1--9: **/ 9** Inattentive: > 6 / 9 DuPaul: 10--18:_____/ 9 Hyperactive: > 6 / 9 DuPaul: 19--28:_____/ 10 Oppositional Defiant Disorder / Conduct Disorder: > 3 / 10

Child's Name: Date of Birth:

Check the box that best describes the child's behavior over the past 6 months. *If the child is currently taking medication, please rate the child's behavior* ***NOT*** *on medication.*	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
29. Is **fearful, anxious, or worried.**				
30. Is **self-conscious** or easily embarrassed.				
31. Is **afraid to try new things** for fear of making mistakes.				
32. Feels **worthless or inferior**.				
33. **Blames self** for problems, feels guilty.				
34. Feels **lonely, unwanted, or unloved**; complains that "no one loves me."				
35. Is **sad, unhappy, or depressed**.				
36. Is physically **mean to animals**.				
37. **Skips school** without permission.				
38. Has **set fires** on purpose to cause damage.				
39. Has **broken into** someone else's home, business, or car.				
40. Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).				
41. Has **said things like "I wish I were dead"** or has tried to hurt self.				
42. Has **distinct periods where mood is unusually irritable OR unusually good, cheerful, or high** which is clearly excessive or different from normal mood.				
43. Seems to have **compulsions** (repetitive behaviors that this child seems driven to carry out, such as, repeated hand washing, counting, or erasing until holes appear).				
44. Seems to have **obsessions** (persistent or repetitive thoughts that distress this child, such as worry about germs or doors left unlocked).				
45. **Has prolonged temper tantrums** (greater than 20-30 minutes).				
46. **Hears voices** telling the child to do bad things.				
47. Seems **unaware of others existence**, is **uninterested in interacting with others**.				
48. Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness).				
49. Appears **uninterested in activities** children his or her age usually like or participate in.				

50. Does this child's **educational placement** seem appropriate? Comments:		**Y**	**N**
51. Do this child's **parent(s) appear to be invested** in this child's academic success? Comments:		**Y**	**N**
52. Does this child seem **motivated** to learn? Comments:		**Y**	**N**
53 a. Is this child on **medication** for ADHD? **(if yes, please answer 53b- 53e)**	**Don'tKnow**	**Y**	**N**
b. Do you know the **name of the medication and when the child takes it**?		**Y**	**N**
c. If yes, **Medication:** **Times of day** child takes medication (specify am/pm):			
d. Do you believe **medication is helping** this child? Comments:		**Y**	**N**
e. Does the medication seem to work **all school day**? Comments:		**Y**	

(OFFICE USE ONLY) 29—35**:** **/ 7** Anxiety/Depression: **> 3 / 7** 36 —49**:** **/ 14** Mental Health Concerns 50. Education Placement: Y N 51. Invested: Y N 52. Motivation: Y N

Child's Name: Date of Birth:

TEACHER QUESTIONNAIRE: School Performance

Child's Name:

Person(s) completing form: Subject / Time of Class:

Telephone Number: FAX Number:

TEACHERS: For students in Kindergarten through High School, please completely fill out the rest of the packet.

CURRENT: Classroom Behavior

Please check the appropriate box	Above Average		Average		Problematic
1. Understanding verbal instructions	1	2	3	4	5
2. Classroom assignment completion	1	2	3	4	5
3. Organizational skills	1	2	3	4	5
4. Getting homework to and from school	1	2	3	4	5
5. Homework completion	1	2	3	4	5
6. Relationship with peers	1	2	3	4	5
7. Following directions	1	2	3	4	5
8. Disrupting class	1	2	3	4	5
9. Verbal participation in class	1	2	3	4	5

CURRENT: School Performance

Please check the appropriate box	Above Average		Average		Problematic
1. Reading decoding	1	2	3	4	5
2. Reading comprehension	1	2	3	4	5
3. Reading rate/fluency	1	2	3	4	5
4. Spelling accuracy	1	2	3	4	5
5. Mathematics concepts	1	2	3	4	5
6. Mathematics computation	1	2	3	4	5
7. Handwriting	1	2	3	4	5
8. Writing rate	1	2	3	4	5
9. Punctuation/grammar	1	2	3	4	5
10. Ability to express thoughts through writing	1	2	3	4	5
11. Gross motor skills	1	2	3	4	5
12. Fine motor skills (using pencil & scissors)	1	2	3	4	5

CURRENT: Summary

Please **summarize this child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare this child's functioning in 2 settings--at school, and with peers, to "average children" his/her age thatyou are familiar with from your experience. **Please circle only one number.**

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
7	**Needs 24-hour <u>professional</u> care and supervision** due to severe behavior or gross impairment(s)

(OFFICE USE ONLY) Behavior: Y N School Performance: Y N Impairment ~~=~~ > **4**: Y N

Child's Name: Date of Birth:

TEACHER QUESTIONNAIRE: School Performance *(continued)*

HISTORY: Learning Problems

We are interested in whether or not this child has learning problems **above and beyond** what would be expected for **his or her developmental age**.				
Check the box that best describes the child's learning problems over the past 6 months.	**Never Rarely 0**	**Occa-sionally 1**	**Often 2**	**Very often 3**
1. Has trouble **learning new material** in an appropriate time frame for age and skills.				
2. Has little **desire to master** new skills.				
3. **Unable to tell time,** days of the week, months of the year.				
4. Can't **repeat information**.				
5. **Knows material one day; doesn't know it the next**.				
6. Has trouble **holding several different things in mind** while working.				
7. Has trouble **following multi-step directions**.				
8. Has difficulty **copying written material** from blackboard.				
9. Difficulty **orienting self** (i.e., gets lost, can't find way, or gets turned around easily).				
10. Has poor **spatial judgment** and often bumps into things.				
11. Confuses **directionality** (up/down, left/right, over/under).				
12. Has poor **spatial organization** on paper (difficulty staying in lines, maintaining space between words, staying within page margins).				
13. **Mixes up capital and lower** case letters when writing.				
14. **Reverses letters and numbers.**				
15. Has trouble **expressing words** or events in **correct order**.				
16. Often **mispronounces known or familiar words** or uses wrong word.				
17. Has trouble **verbally expressing thoughts**.				
18. Says things that have **little or no connection to what others are discussing**.				
19. Has difficulty **distinguishing long vowel sounds and short vowel sounds**.				
20. Depends on teacher or others for repetition of task instructions.				
21. Displays **poor word attack skills** (can't sound out words).				
22. Puts wrong **number of letters in words**.				
23. **Confuses consonant sounds**, for example: d-b, d-t, m-n, p-b, f-v, s-z.				
24. Unable to **keep place on page** when reading.				

Do you have any **additional comments** that you think would be helpful?

(OFFICE USE ONLY) **1—8:** / 8 General: > 4 / 8 **9—14:** / 6 Visual/Spatial Processing: > 3 / 6 **15—20:**____/ 6 Language: > 3 / 6 **21—24:** / 4 Reading/Writing: > 2/4

MEDCIAL PROVIDER USE ONLY