Dear Parent/Guardian:

We are pleased that you have expressed an interest in obtaining services for your child at the Institute for Child Development.

As a major division of the Joseph M. Sanzari Children’s Hospital at Hackensack University Medical Center, the Institute for Child Development offers a wide range of services for children with developmental and behavioral concerns.

This packet includes information regarding our evaluation process and several forms that you will need to complete. Please pay particular attention to information regarding registration and insurance reimbursement.

If you have any questions, please feel free to contact our Appointment Office at 551-996-5555 for assistance.

We look forward to the opportunity of assisting you and your child.

Sincerely,

Randye F. Huron, M.D.
Director

RFH/md
ICD evaluations are designed to determine your child’s strengths and weaknesses, to formulate diagnoses and to make recommendations regarding specific therapeutic and/or educational interventions. A parent/guardian is required to be present for the evaluation which lasts approximately 1 to 2 hours. The parent(s)/guardian(s) will need to be interviewed as part of the evaluation. Since personal/sensitive information may be discussed during part of this interview and as part of the informing conference following the evaluation, it is recommended that you bring someone with you to supervise your child in the waiting room for those times.

To ensure that the professionals have the information that they need to help you and your child, mail or fax the following information (551-996-5034). In addition, we would appreciate if you would please send copies of past medical or educational evaluations, if available.

The following information must be completed by the parent/guardian:

1. Parent/guardian Questionnaire
2. Release forms
3. Behavior Rating Scale (ages 3 and up)
4. Copy of your child’s IFSP (Individualized Family Service Plan), if your child receives special education or IFSP (Individual Family Service Plan) if your child receives early intervention services.
5. If your child has had standardized testing within the past year, name and dates of tests are required before scheduling evaluations.

The child’s teacher should complete the following information:

1. Behavior Rating Scales (ages 3 and up)
2. S.I.F.T.E.R. (ages 6 and up)
3. Classroom Teacher’s Statement

Please bring the following:
- Assistive devices, if appropriate for your child, e.g., glasses, hearing aids, orthotics, augmentative communicative aids
- A pair of short for Physical and Occupational Therapy evaluations

An Audiological evaluation is necessary prior to the Speech-Language Evaluation. To schedule your audiology appointment, please call 551-996-5337.

It is essential that all appointments be kept at the scheduled times. Please allow at least 15 minutes for registration prior to your evaluation. You must bring your insurance card(s) and personal identification. At least 24 hours notice for cancellation of an appointment is requested. Call 551-996-5555 if you need to cancel or reschedule your appointment.
In order for HackensackUMC to bill the insurance company directly, it is important to check with your physician or insurance carrier regarding their correct procedure for your type of insurance coverage. **Many insurance companies require referrals and/or pre-certification for certain services.** It is important to realize that a referral does not necessarily guarantee full coverage depending on the type of services that your insurance company covers. Some evaluations or therapy services at the ICD may not qualify as a covered service under your insurance plan. For clarification about the level of reimbursement you are eligible for under your plan, you should speak to your insurance company. **Please be aware that you will be responsible for any outstanding balance if it is deemed that the services at ICD are not a covered service under your plan or you have not properly followed the referral or pre-certification requirements set forth by your insurance plan.** Insurance procedure codes are included in this parent packet, in order to assist in determining insurance reimbursement. **ICD bills as an Outpatient Facility and your deductible may apply.**

If you have obtained a referral and/or prescription from your primary physician for evaluations, please bring a copy of the referral for registration. If you have not obtained your referral at the time of your registration and your insurance company requires it, we cannot bill your insurance company directly. Therefore, you have the option of registering self-pay, or rescheduling your appointment at a later date once you have obtained your referral.

If you have not qualified for any assistance and do not have insurance you will be billed directly and full payment is expected for services. If you cannot pay your bill in full, payment arrangements may be arranged through the billing department (551-996-3355) for outstanding balances.

Please provide the information on the next page for registration.

Thank you for your cooperation.
PARENT QUESTIONNAIRE

We appreciate your cooperation in completing this questionnaire as fully as possible. The information will be useful in evaluating your child and addressing your concerns.

Date: ____________________  Child’s Name ________________________________

Name of person completing this form ______________________________________
Relationship to child ____________________________________________________

REGISTRATION AND INSURANCE INFORMATION

Child’s Date of Birth: ____________________
Sex:   Male ___ Female ___
Street Address: ____________________ Apt: ____________________
City: ____________________ State: ____________________ Zip code: ______
County: ____________________
Home phone: ____________________ Work phone: ____________________
Cell phone 1: ____________________ Cell phone 2: ____________________
E-Mail address: ____________________
Language(s) spoken at home: ____________________
What language is easiest for your child to understand and to speak? ______
Has your child ever been seen at HackensackUMC before?  Yes ___ No ___
Referred by: ____________________
Name of Pediatrician: ____________________
Address: ____________________
Phone: ____________________

Biological Father: ____________________ Birth Date ____________________
Occupation: ____________________ Religion: ____________________
Ethnic Background: ____________________ Race: ____________________
Years of Schooling: ____________________ Health: ____________________

Biological Mother: ____________________ Birth Date ____________________
Occupation: ____________________ Religion: ____________________
Ethnic Background: ____________________ Race: ____________________
Years of Schooling: ____________________ Health: ____________________
Step/Adopted/Foster Father (Please circle) ______________________________________
Birth Date: ______________
Occupation __________________________ Religion ___________________________
Ethnic Background __________________________ Race ___________________________
Years of Schooling _______ Health: _______________________________________

Step/Adopted/Foster Mother (Please circle) ______________________________________
Birth Date: ______________
Occupation __________________________ Religion ___________________________
Ethnic Background __________________________ Race ___________________________
Years of Schooling _______ Health: _______________________________________

Legal Guardian (if applicable) __________________________ (Relationship) _________

Insurance Information

Plan 1:
Name of Insurance: _________________________________________________________
Plan name: _______________________________________________________________
(Indemnity ____ HMO ____ PPO ____ POS ____ Other ____________) 
Policy ID/Member #: ______________________________ Group #: _______________________
Phone no. for providers: _______________________________ Date of Birth: ______________
Subscriber’s name: ______________________________ Relation to Child: ______________
Occupation: __________________________________________________________________
Employer: __________________________________________________________________
Employer’s address: __________________________________________________________________
Employer’s phone number: __________________________________________________________________

Plan 2:
Name of Insurance: _________________________________________________________
Plan name: _______________________________________________________________
(Indemnity ____ HMO ____ PPO ____ POS ____ Other ____________) 
Policy ID/Member #: ______________________________ Group #: _______________________
Phone no. for providers: _______________________________ Date of Birth: ______________
Subscriber’s name: ______________________________ Relation to Child: ______________
Occupation: __________________________________________________________________
Employer: __________________________________________________________________
Employer’s address: __________________________________________________________________
Employer’s phone number: __________________________________________________________________

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S).
GENERAL INFORMATION

What concerns and questions do you have about your child? _____________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

When was it first noticed?
What have you been told about this/these problems(s)? ________________________________

________________________________________________________________________________

________________________________________________________________________________

Previous diagnoses (if applicable): __________________________________________________

How do you think that the ICD might be able to help you? ______________________________

________________________________________________________________________________

________________________________________________________________________________

PREGNANCY

How old were you when you became pregnant with this child? ____________________________

Please list medicines taken while pregnant and when (include all medications such as
antibiotics, narcotics, vitamins, birth control pills, aspirin, etc.): __________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Did you smoke during the pregnancy? Yes____ No _____

How many cigarettes per day? ____________________________

Number of alcoholic drinks per week ____________________________ if so, when? ______________

Any street drugs taken during or prior to this pregnancy? (e.g., heroin, cocaine, marijuana)
Yes _____ No _____, If so, when? __________________________________________________________________

Any illnesses, hospitalizations. If so, when? __________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

CHILD'S BIRTH HISTORY

Hospital (place of birth) __________________________

Was the baby born on time, early, or late? (Please circle one)
Number of weeks early or late: __________________________

Type of Delivery: Natural (vaginal)____ Breech______ Forceps______

Cesarean section______ Vacuum extraction_______
Baby's birth weight _______ Birth length _______ Head circumference _______
Infant's condition:
  Breathed immediately? ____________ Cried immediately ____________
  Required oxygen? ____________ Length of stay in nursery ____________
  Apgar Score ____________

Problems during the hospital stay (i.e., incubator, respiratory distress syndrome, oxygen therapy, jaundice, feeding difficulties, bleeding tendency, infection, antibiotics, seizures, intraventricular bleed, surgery). Circle above and describe below.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Medicines given to the infant during hospital stay
____________________________________________________________________

Was a newborn hearing screening done: Yes _____ No _____
Results (if known) ___________________________________________________
Was newborn considered (by birth certificate questionnaire) to be at risk for a hearing loss? Yes _____ No _____

OTHER PREGNANCIES

Pregnancies of child's biological mother:
Total number of times pregnant ______________(please indicate number)
Live births _______ Stillbirths _______ Miscarriages _______ Abortion _______

<table>
<thead>
<tr>
<th>Live births</th>
<th>Birth Date</th>
<th>Birth Weight</th>
<th>Grade in School</th>
<th>Any School/Health Problems/ Birth Defects</th>
</tr>
</thead>
<tbody>
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</table>

Are the mother and father cousins, or related in any way?
Yes _____ No _____ If so, what is the relationship (e.g., first cousin, second cousin)

____________________________________________________________________

Please list other children in the family (not listed above):

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>School/Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
DEVELOPMENT

Indicate the age when your child first did each of the following:

Held head erect ____________________________
Rolled over back to front ____________________________
Rolled over front to back ____________________________
Sat alone ____________________________
Stood alone ____________________________
Walked without holding ____________________________
Toilet training started ____________________________
Toilet training finished ____________________________
Said “mama” or “dada” with meaning ____________________________
Responded to name being called ____________________________
Used single words with meaning ____________________________
Used two or more different words together ____________________________

Is your child left or right-handed? ____________________________
When did you first notice a hand preference? ____________________________

CHILD'S HEALTH

Breast fed: Yes ___ No ___ Bottle-fed: Yes ___ No ___ Any difficulties? ____________________________
If your child has had any of the following, please indicate and explain details:

Accidents (e.g., fractures, head injuries, etc.) ____________________________
Serious infections/hospitalizations ____________________________

Anemia ____________________________
Urinary tract infections or disease ____________________________
Bed-wetting, soiling ____________________________
Constipation ____________________________
Trouble seeing ____________________________
Eye turning in/out ____________________________
Frequent ear infections ____________________________
Speech problems ____________________________
Difficulty eating or feeding self ____________________________
Difficulties with: Swallowing _______ Chewing _______ Drooling _______
Asthma ____________________________
Allergies ____________________________
Seizures or convulsions ____________________________
Foot problems (any special shoes, braces, casts, etc.) ____________________________
Poor coordination/frequent falls ____________________________
Fears ____________________________
Sleeping difficulties or night terrors ____________________________
Head banging ____________________________
Rocking ____________________________
Breath holding
Temper tantrums
Behavior Problems
Emotional Problems
Other illnesses

Please list present medication(s) and dosage(s).

 Has your child had a lead screening test done? Yes ___ No ___ Results ________________
Are immunizations up to date: Yes___ No ___ Reason ________________________________
Has your child been hospitalized or seen by any medical specialists since birth?
Yes ___ No ___. If yes, please list information on release form.

Has your child ever been examined by a dentist? Yes _____ No _____
For what reason __________________________________________________________________

FAMILY MEDICAL HISTORY

Do any of your child's relatives have a history of medical, emotional/behavioral or school
problems? Please indicate below the type of problem and age of the relative. Do not
list the names of relatives. List problem such as: Behavior problems, birth defect,
cancer, cerebral palsy, convulsions, diabetes, epilepsy, hearing or vision problems, mental
retardation, miscarriage, muscular disorders, psychiatric problems, school or learning
problems, slow development, speech or language problems, thyroid disease, etc.

Maternal Relatives

Child's Mother ___________________________  Child's Father _________________________
Mother's Mother ___________________________  Father's Mother _______________________
Mother's Father ___________________________  Father's Father _______________________
Mother's Sisters And Brothers ___________________________  Father's Sisters
And Brothers ___________________________  Child's Cousins _______________________

Child's Cousins ___________________________
DAILY ACTIVITIES AND BEHAVIOR

What does your child like to do? ______________________________________________________

________________________________________________________________________________

Does your child recognize dangerous situations and avoid simple hazards? ________________

________________________________________________________________________________

How does your child play and/or get along with other children? ____________________________

________________________________________________________________________________

________________________________________________________________________________

Does your child respond to his/her name being called? Yes___ No ___
Does your child prefer to play alone? Yes ___ No ___
Does your child enjoy being touched or cuddled? Yes ___ No ___
Does your child enjoy bath time? Yes ___ No ___
Is your child easily comforted in times of distress? Yes ___ No ___
Is your child difficult to discipline? Yes ___ No ___

ENVIRONMENT

List all persons currently living in the home:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Any recent major family problems such as death, illness, separation or accident? __________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Describe any family tensions __________________________________________________________

________________________________________________________________________________

PLEASE COMPLETE THE FOLLOWING IF YOUR CHILD IS OF SCHOOL AGE OR IS ATTENDING ANY SPECIAL PROGRAM/ THERAPIES.

Has your child been registered with Special Child Health Services? Yes _____ No _____

Does/did your child receive Early Intervention services? Yes ___ No ___
Please list: ________________________________________________________________
What school does your child attend? (Include, preschools, day care centers)

<table>
<thead>
<tr>
<th>Name/Location</th>
<th>Grade/Class</th>
<th>Special Services (e.g. therapies)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Any school problems?  

May we contact your child’s teacher? Yes ____ No ____. If yes, please list information on release form.

Has your child ever been “classified” for special education  Yes ____ No ____  
Please explain:  

Has your child ever been held back in school?  Yes ____ No ____  
Please explain:  

Has your child ever had private evaluations, tutoring, therapy?  
Please explain:  

What are your child’s academic strengths?  
_________________________________________________________  
_________________________________________________________  
_________________________________________________________  

What are your child’s academic weaknesses?  
_________________________________________________________  
_________________________________________________________  
_________________________________________________________  

Are you satisfied with your child’s school program? Yes ____ No ____  
Please explain below:  
_________________________________________________________  
_________________________________________________________  
_________________________________________________________  

What are your goals and expectations for your child’s education?  
___________________________________________________________________________

NOTE: Please be sure your child’s teacher(s) fill out the:

1. “Classroom Teachers Statement”.

2. Behavioral Checklist (ages 3 and up).

3. S.I.F.T.E.R. (ages 6 and up) and return to us.
ADDITIONAL INFORMATION

Please include any additional information that this questionnaire may not have covered that will assist in the evaluation of your child.
BEHAVIORAL RATING SCALE (Parent/Guardian)

Child’s Name: ___________________________ Age: _______ Grade: _______ Date: ___

Circle the number in the one column which best describes the child.

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Just a little</th>
<th>Pretty much</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Often fails to pay close attention to details or often makes careless mistakes in school-work or other activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>Often has difficulty sustaining attention in tasks or play activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>Often does not seem to listen when spoken to directly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>Often does not follow through on instructions and fails to finish school work or chores</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>Often has difficulty organizing tasks and activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>Often avoids, dislikes, or is reluctant to engage in tasks that require sustained effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>Often loses things necessary for tasks or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>Is often easily distracted by extraneous stimuli.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>If often forgetful in daily activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
**Behavioral Rating Scale**

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Just a little</th>
<th>Pretty much</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Often fidgets with hands or feet or squirms in seat.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Often leaves seat in classroom or other situations in which remaining seated is expected.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Often runs about or climbs excessively in situations in which it is inappropriate.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Often has difficulty playing or engaging in leisure activities quietly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is often “on the go” or acts as if “driven by a motor”.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Often talks excessively.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Often blurts out answers before questions have been completed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Often interrupts or intrudes on others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Often has difficulty awaiting turn.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Completed by: ____________________________

PRM/md
**Authorization to Use or Disclose Protected Health Information**

I hereby authorize use or disclosure of the named individual's health information as described below.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
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</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Address (Street, City, State, Zip Code)  

<table>
<thead>
<tr>
<th>Telephone Number</th>
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</thead>
<tbody>
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</tbody>
</table>

The following individual or organization is authorized to make the disclosure:
- [ ] Hackensack University Medical Center
- [ ] Other (please specify) Pediatrician: (specify)

This information may be disclosed to and used by the following individual or organization:
- [ ] Hackensack University Medical Center
- [ ] Other (please specify)

<table>
<thead>
<tr>
<th>Treatment dates:</th>
<th>Purpose of Request:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

The following information is to be disclosed: (please check)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
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</tbody>
</table>

- [ ] Discharge Summary
- [ ] History & Physical Examination
- [ ] Consultations (including psychiatric evaluations)
- [ ] Operative Report or Procedure Reports
- [ ] Emergency Department Record
- [ ] Laboratory Reports (including drug screens)
- [ ] Radiology or Imaging Reports
- [ ] Cardiac Studies
- [ ] Interdisciplinary Records (Progress Notes)
- [ ] Medication Records
- [ ] Nursing Notes
- [ ] Physician Orders
- [ ] Complete Record
- [ ] Other

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

Expiration Date:

If I do not specify an expiration date, event or condition, this authorization will expire in six months.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

If I have any questions about disclosure of my health information, I can contact the Systems Manager in the Health Information Management Department at 201-996-2075.

Signature of Patient or Legal Representative: ____________________________

Date: ____________________________

If signed by Legal Representative, relationship to patient: ____________________________
# Authorization to Use or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Address (Street, City, State, Zip Code) Telephone Number

The following individual or organization is authorized to make the disclosure:

- Hackensack University Medical Center
- Medical Specialist (specify):

This information may be disclosed to and used by the following individual or organization:

- Hackensack University Medical Center
- Other (please specify):

<table>
<thead>
<tr>
<th>Treatment dates:</th>
<th>Purpose of Request:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

The following information is to be disclosed: (please check)

- ☐ Yes
- ☑ No

- □ Discharge Summary
- □ History & Physical Examination
- □ Consultations (including psychiatric evaluations)
- □ Operative Report or Procedure Reports
- □ Emergency Department Record
- □ Laboratory Reports (Including drug screens)
- □ Radiology or Imaging Reports
- □ Cardiac Studies
- □ Interdisciplinary Records (Progress Notes)
- □ Medication Records
- □ Nursing Notes
- □ Physician Orders
- □ Complete Record
- □ Other

**Sensitive Information:** I understand that the information in this record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

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**Signature of Patient or Legal Representative**

Date

If Signed by Legal Representative, Relationship to Patient
Dear Teacher,

Your student is having a comprehensive evaluation at the Institute for Child Development. Any information you can provide us regarding his/her school performance would be very helpful to us in understanding him/her better. Please take a few moments to fill out the attached forms (Classroom Teacher's Remarks, Behavioral Rating Scale and S.I.F.T.E.R.). Please make copies for additional teachers.

Thank you for taking the time to assist us.

Sincerely,

Randye F. Huron, M.D.
Director

RFH/md 4-13
CLASSROOM TEACHER’S REMARKS

Child: Date of Birth:
Age: School:
Grade/Class: Bilingual Class: Yes  No (circle)
ESL: Yes  No (circle)
Primary language of instruction: ____________________________
Student’s primary language: ________________________________
Special Services (circle): IEP, Section 504, BSI, other ____________________________

Teacher’s name: ____________________________ Date: ___________

Instructions: Please include remarks regarding academic performance, work style, social behavior and attitude. Please feel free to attach work samples.

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Signed

7-06/md
# BEHAVIORAL RATING SCALE

Child's Name: ___________________ Age: _______ Grade: _______ Date:______

Circle the number in the one column which best describes the child.

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Just a little</th>
<th>Pretty much</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Often fails to pay close attention to details or often makes careless mistakes in school-work or other activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>Often has difficulty sustaining attention in tasks or play activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>Often does not seem to listen when spoken to directly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>Often does not follow through on instructions and fails to finish school work or chores</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>Often has difficulty organizing tasks and activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>Often avoids, dislikes, or is reluctant to engage in tasks that require sustained effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>Often loses things necessary for tasks or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>Is often easily distracted by extraneous stimuli.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>If often forgetful in daily activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Not at all</td>
<td>Just a little</td>
<td>Pretty much</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>10.</td>
<td>Often fidgets with hands or feet or squirms in seat.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11.</td>
<td>Often leaves seat in classroom or other situations in which remaining seated is expected.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>Often runs about or climbs excessively in situations in which it is inappropriate.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13.</td>
<td>Often has difficulty playing or engaging in leisure activities quietly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14.</td>
<td>Is often “on the go” or acts as if “driven by a motor”.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>Often talks excessively.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>Often blurts out answers before questions have been completed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17.</td>
<td>Often interrupts or intrudes on others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18.</td>
<td>Often has difficulty awaiting turn.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Completed by: __________________________
S.I.F.T.E.R.
SCREENING INSTRUMENT FOR TARGETING EDUCATIONAL RISK
by Karen L. Anderson, Ed.S., CCC-A

<table>
<thead>
<tr>
<th>STUDENT</th>
<th>TEACHER</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE COMPLETED</th>
<th>SCHOOL</th>
<th>DISTRICT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above child is suspect for hearing problems which may or may not be affecting his/her school performance. This rating scale has been designed to sift out students who are educationally at risk possibly as a result of hearing problems. Based on your knowledge from observations of this student, circle the number best representing his/her behavior. After answering the questions, please record any comments about the student in the space provided on the reverse side.

<table>
<thead>
<tr>
<th>1. What is your estimate of the student's class standing in comparison of that of his/her classmates?</th>
<th>UPPER</th>
<th>MIDDLE</th>
<th>LOWER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. How does the student's achievement compare to your estimation of her/his potential?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EQUAL</td>
<td>LOWER</td>
<td>MUCH LOWER</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

| 3. What is the student's reading level, reading ability group or reading readiness group in the classroom (e.g., a student with average reading ability performs in the middle group)? | UPPER | MIDDLE | LOWER |
|                                                                                                  | 5     | 4      | 3     | 2     | 1     |

<table>
<thead>
<tr>
<th>4. How distractible is the student in comparison to his/her classmates?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOT VERY</td>
<td>AVERAGE</td>
<td>VERY</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. What is the student's attention span in comparison to that of his/her classmates?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LONGER</td>
<td>AVERAGE</td>
<td>SHORTER</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. How often does the student hesitate or become confused when responding to oral directions (e.g., &quot;Turn to page . . .&quot;)?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>OCCASIONALLY</td>
<td>FREQUENTLY</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. How does the student's comprehension compare to the average understanding ability of her/his classmates?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ABOVE</td>
<td>AVERAGE</td>
<td>BELOW</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. How does the student's vocabulary and word usage skills compare with those of other students in his/her age group?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ABOVE</td>
<td>AVERAGE</td>
<td>BELOW</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. How proficient is the student at telling a story or relating happenings from home when compared to classmates?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ABOVE</td>
<td>AVERAGE</td>
<td>BELOW</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. How often does the student volunteer information to class discussions or in answer to teacher questions?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FREQUENTLY</td>
<td>OCCASIONALLY</td>
<td>NEVER</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. With what frequency does the student complete his/her class and homework assignments within the time allocated?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALWAYS</td>
<td>USUALLY</td>
<td>SELDOM</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. After instruction, does the student have difficulty starting to work (looks at other students working or asks for help)?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>OCCASIONALLY</td>
<td>FREQUENTLY</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Does the student demonstrate any behaviors that seem unusual or inappropriate when compared to other students?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>OCCASIONALLY</td>
<td>FREQUENTLY</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Does the student become frustrated easily, sometimes to the point of losing emotional control?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>OCCASIONALLY</td>
<td>FREQUENTLY</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15. In general, how would you rank the student's relationship with peers (ability to get along with others)?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GOOD</td>
<td>AVERAGE</td>
<td>POOR</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

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TEACHER COMMENTS
Has this child repeated a grade, had frequent absences or experienced health problems (including ear infections and colds)? Has the student received, or is he/she now receiving, special services? Does the child have any other health problems that may be pertinent to his/her educational functioning?

The S.I.F.T.E.R. is a SCREENING TOOL ONLY
Any student failing this screening in a content area as determined on the scoring grid below should be considered for further assessment, depending on his/her individual needs as per school district criteria. For example, failing in the Academics area suggests an educational assessment, in the Communication area a speech-language assessment, and in the School Behavior area an assessment by a psychologist or a social worker. Failing in the Attention and/or Class Participation area in combination with other areas may suggest an evaluation by an educational audiologist. Children placed in the marginal area are at risk for failing and should be monitored or considered for assessment depending upon additional information.

SCORING
Sum the responses to the three questions in each content area and record in the appropriate box on the reverse side and under Total Score below. Place an X on the number that corresponds most closely with the content area score (e.g., if a teacher circled 3, 4 and 2 for the questions in the Academics area, an X would be placed on the number 9 across from the Academics content area). Connect the X's to make a profile.

<table>
<thead>
<tr>
<th>CONTENT AREA</th>
<th>TOTAL SCORE</th>
<th>PASS</th>
<th>MARGINAL</th>
<th>FAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACADEMICS</td>
<td>15</td>
<td>14 13 12 11 10</td>
<td>9 8</td>
<td>7 6 5 4 3</td>
</tr>
<tr>
<td>ATTENTION</td>
<td>15</td>
<td>14 13 12 11 10 9</td>
<td>8 7</td>
<td>6 5 4 3</td>
</tr>
<tr>
<td>COMMUNICATION</td>
<td>15</td>
<td>14 13 12 11 10</td>
<td>10 9 8</td>
<td>7 6 5 4 3</td>
</tr>
<tr>
<td>CLASS PARTICIPATION</td>
<td>15</td>
<td>14 13 12 11 10 9</td>
<td>8 7</td>
<td>6 5 4 3</td>
</tr>
<tr>
<td>SOCIAL BEHAVIOR</td>
<td>15</td>
<td>14 13 12 11 10</td>
<td>9 8</td>
<td>7 6 5 4 3</td>
</tr>
</tbody>
</table>
DIRECTIONS TO THE INSTITUTE FOR CHILD DEVELOPMENT

The Don Imus/WFAN Pediatric Center is located on the corner of Atlantic Street and Second Avenue. For GPS directions enter 60 Second Street, Hackensack, NJ. The Pediatric Center parking garage is directly across the street (under the building) with entrance on Second Street. Press the red button to access garage. Take elevator to G, turn left, and proceed through glass doors to next set of elevators. Take elevator to 1st or 2nd floor.

First Floor:
Physical and Occupational Therapy
Audiology
Patient Registration

Second Floor:
Appointments Office
Developmental Pediatrics
Communication Disorders
Patient Registration

From George Washington Bridge and East: Follow Rt. 80 West, (local lane) to Exit 64B. Turn Right at light onto Polifly Rd. (North). At second light turn left onto Essex St. At first light turn right onto Prospect Ave. Turn right onto Atlantic St., then right onto Second Ave. then an immediate right turn into the WFAN building garage.

From Paterson area and West:
Follow Rt. 80 East (local lanes) to Exit 63 for Rochelle Park and Paramus. Turn left off exit ramp and then turn right at light onto Essex St. At fourth light turn left onto Prospect Ave. Follow as above from Prospect Ave.

From Southern New Jersey on the NJ Turnpike:
Follow NJ Turnpike North to Rt. 80. Take 80 West (local lanes) to exit 64B. Turn Rt. onto Polifly Rd and proceed as directed as above *

From Route 17:
Traveling North, take Essex St. Exit. Turn right onto Essex St. At fourth light turn left onto Prospect Ave. Follow as above * to Atlantic St.
Traveling South, take Essex St. Exit. Turn left onto Essex St. At fourth light, turn left onto Prospect Ave. Follow as above * to Atlantic St.

From Garden State Parkway:
From the Garden State Parkway, either north or south. Take Rt. 80 East. Proceed as above for Paterson and West.
## Insurance Procedure Codes

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Pediatric Study</td>
<td>99245</td>
</tr>
<tr>
<td>Occupational Therapy Evaluation</td>
<td>97003</td>
</tr>
<tr>
<td>OT Re-Evaluation</td>
<td>97004</td>
</tr>
<tr>
<td>Physical Therapy Evaluation</td>
<td>97001</td>
</tr>
<tr>
<td>PT Re-Evaluation</td>
<td>97002</td>
</tr>
<tr>
<td>Oral Motor Evaluation</td>
<td>92610</td>
</tr>
<tr>
<td>Speech/Language Evaluation</td>
<td>92506</td>
</tr>
<tr>
<td>Initial High Risk Infant Follow-Up Evaluation</td>
<td>99245</td>
</tr>
<tr>
<td>High Risk Infant Follow-Up Re-Evaluation</td>
<td>99215</td>
</tr>
<tr>
<td>Judy Program Initial Evaluation</td>
<td>99205</td>
</tr>
<tr>
<td>Judy Program Re-Evaluation</td>
<td>99215</td>
</tr>
</tbody>
</table>