Onslow MEMORIAL HOSPITAL
An Affiliate of UNC Health Care

315-2 Western Blvd.
Jacksonville, NC 28546
910-577-2372 (Phone)
910-577-2625 (Fax)

OUTPATIENT REHABILITATION

Date: _____

Dear Parent or Care Provider:

Please review the information about our Pediatric Therapy Programs. We ask that you read this information and write down your questions so that we may address them at the time of your child's evaluation. Please keep the informational documents and return the ones listed via mail, fax or in person. Completing the documents to us will allow us to schedule your child's evaluation as soon as possible and will help the evaluating therapist(s) understand your child's history and difficulty before his/her evaluation. When you arrive for the actual appointment there will be additional paperwork, *we will need you to arrive at least 15 minutes early*.

Please complete and return the following documents for ***all*** children:

- ☐ Pediatric Agreement Form (page 4)
- ☐ Outpatient Services Policy (page 5)
- ☐ Pediatric Medical History and Summary Log (pages 6 & 7)
- ☐ Sensory Checklist (page 8)

For children referred for a ***feeding evaluation***, please:

- ☐ Complete and return the Feeding Questionnaire (pages 9 & 10)
- ☐ Bring a few foods that your child eats well and a few foods that are difficult to the evaluation.
- ☐ Please bring any utensils (bottles, cups, etc.) that your child needs to eat.
- ☐ It helps if the evaluation is during a time that your child will eat a meal or snack as we need to observe him or her eating.

A self-addressed stamped envelope is enclosed for your convenience to return forms. Upon receiving these documents, our office staff will contact you to set up an appointment for your child's evaluation. **If your child has an IEP from school, you will be required to bring a copy along with your child's prescription** (unless the physician has already faxed an order). Should you have any questions, please call 910-577-2372.

Thank you for choosing Onslow Memorial Rehabilitation. We look forward to working with you and your child!

Sincerely,

The Pediatric Team
Onslow Memorial Hospital Rehabilitation

Family – please keep for your records.

PEDIATRIC THERAPY PROGRAM

Evaluations and treatment are provided as prescribed by a physician. Children eligible for services are those who meet the requirements for medical necessity.

Medical Necessity means that:

- Your child's treatment is reasonable and necessary for his/her diagnosis.
- Measurable, objective progress is likely or has been made by your child within a reasonable period of time with the help of a licensed therapist.
- The treatment can only be provided by a licensed and trained therapist.

Insurance companies reserve the right to deny payment for services after they have been authorized if those visits are not found to meet medical necessity.

Reaching therapy goals is dependent upon parent commitment to the child's home program and on attendance in scheduled therapy sessions.

PARTNERS IN TREATMENT

Our therapists believe strongly in the power of family involvement. Education and instruction provided to parents and care providers is as important as the child's therapy. Families play an important role in following the recommendations for home program activities on a daily basis. Providing medical and developmental information about your child allows the therapists know your child better and assist in building a partnership with child and family. All information remains confidential and becomes part of a confidential medical record. Should other helping professionals require information your consent and signature will be required.

After the evaluation, your child's therapist will develop a treatment plan that will include goals and recommendations including home program activities, equipment if necessary, and the recommended number of treatments and length of treatment period, with precautions, if appropriate. All team members work collaboratively and consultatively following a child's evaluation. Evaluation results, recommendations and goals are provided to the referring physician. Physicians are kept informed of each child's progress every ten treatment sessions.

Your child's therapist has the professional responsibility to discontinue therapy if criterion for skilled and medically necessary services cannot be met.

INSURANCE COVERAGE

Parents are responsible for ensuring insurance coverage is in place before the child's evaluation. Unfortunately some insurance plans do not cover therapy services for particular diagnoses. Please check your policy. **Be aware of your insurance coverage**, and communicate any changes in insurance or any outside agencies in the payment of your therapy.

Family – Please keep for your records.

SCHEDULING AND ATTENDANCE POLICY

Participation in and consistent attendance of therapy appointments is important to meet your child's treatment goals. We ask that you:

1. Be on time for your appointment. If you are late, your appointment will be shortened or may need to be re-scheduled.
2. **Schedule future appointments** before leaving the building. **Appointments are NOT automatically rescheduled** at the front office.
3. Reschedule your appointments weekly to ensure that your scheduling preferences are reserved.
4. Cancel appointments **day before appointment by 5:30 PM** and call us if there will be a change in your schedule or you are unable to make future appointments.
5. Know that **missed appointments** without proper notification may result in **discontinuation of therapy services.** Appointments cancelled by 5:30 PM day before appointment are not missed – they are deleted.
6. Keep your therapist informed of your personal schedule. **Extended absences may result in discontinuation of services.**
7. Understand that a pattern of missed appointments will result in being unable to schedule more than one appointment in advance. Appointments already scheduled will be cancelled.

REQUESTS

1. Children should wear comfortable clothing, socks, and shoes to enable them to participate fully in therapy.
2. Please be prepared for toileting emergencies. Your therapist may require your assistance if your child has an accident.
3. Notify your therapist in advance for permission for a case worker or other professional to observe therapy.
4. **Cancel your appointment when your child has a fever, diarrhea, is vomiting, or has a contagious skin condition. Therapy is ineffective and stressful on children who are not feeling well. To cancel, please call 577-2372.**

SAFETY REQUIREMENTS

- **Parents or legal guardians must be present during a child's initial evaluation (UNDER AGE 18).**
- For emergency purposes, we require **all parents (or designated adult) of minor children (under age 18) to remain on premises** and in the lobby while their children are receiving therapy.
- **If parents wish to send a designated adult to transport and wait for their child during therapy, a form must be completed and signed indicating the name and relationship of the designated adult. This must be done prior to the first follow-up visit.** A parent or designated adult must be available to receive your child at the end of the session, as our therapy staff will need to be available and on time for their next patient's appointment.
- Close supervision must be provided to children in the lobby who are not receiving therapy.
- **Written permission must be provided to release a child to anyone other than the parent or legal guardian.**
- **Emergency contact numbers must be provided.**

Family – Please keep for your records.

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PEDIATRIC AGREEMENT FORM

PLEASE SIGN BELOW, A AND B, AND RETURN WITH PEDIATRIC MEDICAL HISTORY FORMS.

A. ATTENDANCE POLICY

Date: _____

I have received a copy of the "Pediatric Therapy Program" and "Scheduling and Attendance Policy" and have reviewed the attendance and safety requirements. I understand my child may be unable to receive continued therapy if compliance with the attendance and cancellation policy is not followed.

_____
Signature Parent or Guardian

B. PERMISSION TO TREAT

Date: _____

I have read and understand the safety policy of Onslow Memorial Hospital Outpatient Rehabilitation Services Department regarding the treatment of my minor child(ren) in my absence.

My child, _____, may receive therapy at Onslow Memorial Rehabilitation Center in my absence. I have appointed _____, known to me as: *(circle)* a friend, neighbor, relative, to transport my child to therapy and to remain on premises at Onslow Memorial Rehabilitation Center for the entire time my child is in therapy. In the event of an emergency, I can be reached at _____.

I understand that any changes in the above information will require an updated form. I also understand that I am required to return at the first visit of each new month to sign the necessary forms.

_____
Signature: Parent / Guardian

_____
Witness

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315-2 Western Blvd.
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OUTPATIENT SERVICES POLICY

Child's Name_____ **Date of Birth**_____

I understand that I am responsible for scheduling and attending my appointments as recommended by my therapist and my doctor and confirm that I have read or received a copy of the attendance policy.

I understand that it is my responsibility to be aware of my child's insurance coverage and the number of visits allowed for current or future treatments.

I understand it is my obligation to inform the department of any change, or upcoming change, my or my child's insurance coverage.

I understand that it is my responsibility to inform my therapist if I am pregnant, if there have been any changes in my medical condition, or if my minor child receiving therapy, is pregnant.

I understand that I may have the opportunity to be visited and/or assisted by a therapy dog during my treatment.
(Please initial) _____ Agreed _____Declined

Communication Release

I authorize staff at Onslow Memorial Rehab Center to leave messages on my voice mail regarding therapy sessions, appointments or scheduling status.

Please list the names of those individuals who are permitted to inquire about or receive information regarding your therapy sessions, appointment schedules, or account status.

Authorized contact name: _____

Relationship to patient: _____

Authorized contact name: _____

Relationship to patient: _____

Signature Parent/Guardian: _____ Date Signed:_____

PEDIATRIC MEDICAL HISTORY AND SUMMARY LOG

Child's Name: _____Date of Birth: _____ Age:_____ Physician: _____

Is your child currently receiving in home therapy (PT, OT or Speech)? Yes / No

****If yes, please call 910-577-2372 before continuing to fill out the forms.****

CAREGIVER/LEGAL GUARDIAN:

Name: _____

Address: _____

_____

Phone: _____(home)_____(mobile)_____(work)

Mother's Name: _____Occupation: _____Age: _____

Father's Name: _____Occupation: _____ Age:_____

Child's Siblings: How many?: _____ Age(s) of Child's Siblings: _____

CONCERNS / REASON FOR SEEKING THERAPY:_____

_____

_____

How do you hope therapy will help your child? _____

_____

PRENATAL / BIRTH HISTORY

Mother's general health during pregnancy / labor (illness, accidents, medications, etc.): _____

Length of pregnancy (weeks gestation): _____ Length of labor: _____ Child's Birth Weight: _____

NICU ? Yes / No Length of Admission: _____ Name of NICU hospital: _____

MEDICAL HISTORY

Current Diagnoses_____

_____

_____

Medical Tests or Procedures?:_____

Describe any major accidents/ injuries, illnesses, hospitalizations:_____

List Medications: _____

List Any Allergies: _____

Specialists who have seen your child: _____

DEVELOPMENTAL HISTORY: Please list your child's age when able to:

Sit Unsupported _____ Crawl _____ Stand Independently _____ Walk _____ Say First Words _____

Combine Two Words _____ Developmental Concerns?_____

SCHOOL / DAYCARE ATTENDANCE

Name of School / Day Care:_____ Telephone: _____

How many days a week does your child attend school or daycare? _____ Grade: _____

THERAPY HISTORY

Previous therapy? Occupational Therapy / Physical Therapy / Speech Therapy / Feeding Therapy / ABA / Play Therapy

Other: _____ When? _____For how long? _____

Did therapy help? Yes / No

Current therapy? Occupational Therapy / Physical Therapy / Speech Therapy / Feeding Therapy / ABA / Play Therapy

Other: _____ How often are services provided? _____

Are any therapy services at a public school? Yes / No Does your child have an IEP? Yes / No

If your child has an IEP, please provide a copy. It may be necessary for insurance authorization.*

SPEECH AND LANGUAGE CHECKLIST: Please check all that apply:

___non-verbal/no words
___does not use sentences (over 3 years)
___sentences do not make sense
___socially inappropriate
___difficulty using grammar
___difficult to understand child's speech
___has difficulty understanding others
___has trouble with certain sounds
___repeats what others say

Bilingual: Yes / No If yes, please list languages spoken at home: _____

BEHAVIORAL / DEVELOPMENTAL CONCERNS CHECKLIST: Please check all that apply:

___doesn't do what he/she is told
___eats non-edibles
___hurts self when frustrated
___temper tantrums
___bites self or others
___hurts others
___body rocking
___difficulty paying attention
___throws objects
___difficulty transitioning between tasks
___overactive
___flaps hands
___difficulty calming self
___separation anxiety
___not potty trained
___potty trained but has accidents
___does not interact (caregiver/peers)
___insists on same way/toys/objects
___needs routine
___ difficulty playing with others
___easily frustrated
___impatient/difficulty waiting

Please list any other concerns that we did not ask about or anything you feel it is important we know about your child:

_____

_____

SENSORY OBSERVATION CHECKLIST

Child's Name:_____ **Child's Date of Birth:**_____

This checklist helps us identify areas that are giving your child difficulty. Based on your observations, please rate your child in the following areas by indicating how often you observe a behavior using the scale never/rarely, sometimes, often, or always.

	Never / Rarely	Sometimes	Often	Always
TACTILE SENSITIVITY				
Upset by grooming (bathing, brushing hair, teeth, etc.)				
Avoids going barefoot – especially in sand or grass				
Easily upset by touch – reacts emotionally or aggressively				
Difficulty standing close to others or in line				
TASTE / SMELL SENSITIVITY				
Avoids certain tastes or food smells that children typically eat				
Will only eat certain tastes, textures, or temperatures of food				
Picky eater				
MOVEMENT SENSITIVITY				
Becomes anxious when feet leave ground				
Fears falling or heights				
Dislikes activities where head is upside down				
SENSORY SEEKING				
Enjoys strange noises / makes noise for noise sake				
Seeks movement - fidgets, can't sit still, etc.				
Touches people & objects				
Doesn't seem to notice when face or hands are messy				
Jumps quickly between activities				

	Never / Rarely	Sometimes	Often	Always
AUDITORY FILTERING				
Is distracted or has trouble functioning if there is noise				
Has difficulty paying attention				
Appears to not hear what you say (doesn't "tune-in")				
Can't work with background noise				
Trouble completing tasks when music is on				
LOW ENERGY / WEAK				
Can't lift heavy objects (compared to same age children)				
Tires easily, especially when standing or holding position				
Seems to have weak muscles				
Has a weak grasp				
Props to support self (even during activity)				
Poor endurance				
VISUAL/AUDITORY SENSITIVITY				
Watches everyone move around room				
Responds negatively to unexpected or loud noises				
Holds hands over ears to protect ears from sound				
Bothered by bright lights after others have adapted to light				
Covers eyes or squints to protect eyes from light				

PEDIATRIC FEEDING QUESTIONNAIRE

This questionnaire is only needed if you are seeking feeding therapy for your child.

Child's Name: _____Date of Birth: _____ Age:_____ Physician: _____

REASON FOR SEEKING THERAPY

Please describe the reason you are seeking feeding therapy for your child: _____

_____

_____

MEDICAL HISTORY

Was your child ever intubated? Yes / No If yes, for how long? _____

Was your child ever fed by a tube? Yes / No If yes, what type? PEG / g-tube / nasogatric For how long? _____

FEEDING HISTORY - INFANT

Please circle all that apply.

Child is: Breast Fed / Bottle Fed / Bottle & Breast / Tube Fed If bottle, type & nipple:_____

Is your child fussy during or after feeding? Yes / No

Does your child arch back before or after feeding? Yes / No

Does your child frequently fall asleep while eating? Yes / No

Does your child frequently spit up? Yes / No

CURRENT FEEDING

How is your child fed currently? Breast Fed / Bottle Fed / Eating solids / Tube Fed

Please circle all consistencies your child eats: Liquids / Baby Food / Mashed / Chopped Foods / Regular Table Foods

Can you child feed him or herself? Yes / No

Does your child gag, cough or choke while eating or drinking? Yes / No

Does food ever come out of your child's nose? Yes / No

Does your child throw up or vomit during or after eating? Yes / No If yes, how often? _____

Is your child's weight a concern for you? Yes / No Child's Current Weight: _____ Percentile: _____

Is your child losing weight? Yes / No

GASTROINTESTINAL

Has your child ever been seen by a gastroenterologist? Yes / No If yes, who/where? _____

Has your child ever been treated for reflux? Yes / No If yes, list treatment: _____

How often does your child have a bowel movement? _____

Does your child have food allergies or intolerances? Yes / No

If yes, please list foods avoided: _____

THERAPY HISTORY

Has your child ever had feeding therapy before? Yes / No

Has your child ever had a Modified Barium Swallow Study or Videofluroscopic Swallow Study? Yes / No

If yes, what were the results? _____

RESPIRATORY

Please list any respiratory problems your child has: _____

Has your child ever had pneumonia? Yes / No If yes, how many times? _____

Has your child ever had bronchitis or chronic upper respiratory infections? Yes / No If yes, how many times? _____

Has your child ever had a tracheostomy? Yes / No If yes, when? _____ Passy-Muir Valve? _____

MEALTIME

What utensils does or can your child currently use to eat? Please list bottles, cups, spoons, etc. _____

_____

About how many foods does your child accept? _____

How long does it take your child to eat an average meal? _____

How often does your child typically eat? _____ (e.g. every 3 hours)

Provide a general sample of when, where what, and how much your child eats at each meal.

Meal	Time	Location	Food Type	Approx. Amount
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Other Snack				

PREFERRED AND NON-PREFERRED FOODS

What are your child's ***favorite*** foods? _____

What are your child's ***least favorite*** foods? _____

Write down the foods that your child will **usually** eat when you serve them for snacks or meals.

Fruits: _____Vegetables:_____

Meats: _____ Starches: _____

Liquids: _____ Junk Food: _____