UC San Diego SCHOOL OF MEDICINE

THE DEVELOPMENTAL-BEHAVIORAL PEDIATRICS CLINIC **Clinic Address: 7910 Frost Street, Suite 280, San Diego, California 92123**

Sheila Gahagan, MD, MPH Division Chief
Yi Hui Liu, MD, MPH Medical Director
Adam Braddock, MD,M.Phil ▪ Lauren Gist, MD, MPH
Theodora Nelson, MD ▪ Carolyn Sawyer, MD

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Dear Parent/Caregiver:

The enclosed brochure explains how to prepare for your appointment at the UCSD Developmental-Behavioral Pediatrics Clinic. Please read the entire brochure **FIRST**, as it may answer your questions or concerns. The following steps outline the process to obtain an appointment:

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 by 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**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, etc. may fill out the school questionnaire instead. **Parents must complete the New patient forms and Parent Questionnaire within two weeks of scheduling your appointment.**

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.

❹ **COMPLETED forms** may be sent to Developmental-Behavioral Pediatrics in one of 3 ways:

Via U.S. Mail - UCSD Pediatric Associates
Attn: 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**
7910 Frost Street, Suite 280 San Diego, CA
92123

❺ 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.

❻ **Scheduling -** After all steps are completed, staff will contact you to schedule your visit.

Please call (858) 246 0053 if you have any questions

We look forward to serving your family!

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
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, 96113x3), several follow-up visits (99215, 99214, 99213), and prolonged service with direct patient contact (99354).*

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 abnormal 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 concerns: ☐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 ☐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 are unable to evaluate children with complex or emergency mental health needs, or those taking multiple psychotropic medications. 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:***

(05/19/2020)

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Developmental-Behavioral Pediatrics
Child Registration Form

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PLEASE PRINT

Child's Name:	**Sex: M F**	**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_____

UCSD Developmental Behavioral Pediatrics

Dear Parents;

Effective October 1, 2015 there will be 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

UC San Diego SCHOOL OF MEDICINE

Developmental-Behavioral Pediatrics
Parent Questionnaire- Under 3 Years

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Child's Name (Last, First) :	Date of Birth:	Age:	Sex : M F	Today's Date:
Address: City: State: Zip:				Phone:
Child's Race (circle) : Hispanic or Latino White American Indian/ Alaskan Native Don't Know Black or African American Asian or Pacific Islander Other, specify: _____				
Child's Doctor:	Doctor's Office Name:			Doctor's Phone:
Name of person completing this form:	Relationship to child:			Phone:

CHIEF CONCERN:

1. **Who** suggested that your child be seen in the clinic for developmental or behavior problems?

2. What **concerns** do you have about your child?

a.

b.

c.

3. **How long** have you been concerned about your child's development or behavior?	**4**. Please check ONE: Overall, the above concerns are ☐ **mild**, ☐ **moderate**, or ☐ **severe**?	**5**. Please check ONE: My concerns are ☐ **improving**, ☐ **staying the same**, or ☐ **getting worse**?

6. Please describe your child's **strongest areas at home**:

a.

b.

c.

7. Goals for Visit: What do you hope to accomplish? (check all that apply):

☐ Better understanding of my child ☐ Guidance for development
☐ To determine a diagnosis ☐ Guidance for behaviors
☐ Medication to help ☐ Guidance for resources

HISTORY: Birth

1. How much did your child weigh at birth? _____ pounds _____ounces

2. Biological Father's age at birth of your child:

3. Biological Mother's age at birth of your child:

4. Number of living children: _____

5. Number of pregnancies prior to your child:

6. Number of miscarriages prior to your child:

Y	N	
		7. Were there any **problems during the pregnancy**? Specify:
		8. Were there any **problems during labor / delivery** or **following the birth**? Specify:
		9. Was your child born by **Cesarean / C-Section**? If yes, circle: **planned** **emergency** If yes, specify why:
		10. Was your child born **two or more weeks before** the "due date"? If yes, how many weeks early was your child?
		11. Were any substances or **medications used by the mother** during the pregnancy? ____Beer / Wine ____Alcohol ____Cocaine ____Prescription medication: ____Tobacco ____Marijuana ____Methamphetamine (Crystal / Ice) ____Other:

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Developmental-Behavioral Pediatrics
Parent Questionnaire- Under 3 Years

Child's Name (Last, First):

HISTORY: Development

Fill in the Age at which your child could:

Sit _____ Say "mama/dada" _____ Use the toilet (able to stay dry during day) _____

Walk _____ Say first word (other than "mama/dada")_____

Say two words together (such as "more milk")_____ Speech could be understood by strangers _____

Check the skills which your child can do for himself or herself:

☐ Undress ☐ Use utensils ☐ Ride a tricycle ☐ Draw lines

☐ Dress ☐ Drink out of a regular open cup ☐ Draw circles

HISTORY: Health

Y	**N**	1. Has your child had any **major or chronic health problems**? Specify:
Y	**N**	2. Has your child ever been **hospitalized?** Specify:
Y	**N**	3. Has your child ever had **surgery**? Specify:
Y	**N**	4. Does your child have any **allergies?** (e.g. medications, foods, environmental) Specify:
Y	**N**	5. Has your child had any **vision/eye** problems? Specify:
Y	**N**	6. Has your child had any **hearing/ear** problems? Specify:
Y	**N**	7. Has your child had frequent **ear infections**?
Y	**N**	8. Does your child have **frequent headaches**? Specify:
Y	**N**	9. Has your child lost **consciousness** or had a **serious head injury**? Specify:
Y	**N**	10. Does your child have problems with **runny nose, congestion, itchy eyes**? Specify:
Y	**N**	11. Does your child have **dental** problems? Specify:
Y	**N**	12. Does your child have any problems with **drooling, swallowing, or choking**? Specify:
Y	**N**	13. Does your child have problems with **breathing, coughing, or catching his/her breath**? Specify
Y	**N**	14. Does your child have any problems with their **heart, rapid heartbeat, chest pain, or fainting**? Specify:
Y	**N**	15. Does your child have **frequent stomachaches**? Specify
Y	**N**	16. Does your child have problems with **heartburn, reflux, nausea, or vomiting**? Specify
Y	**N**	17. Does your child have problems with his/her **bowel movements, diarrhea, or constipation**? Specify
Y	**N**	18. Does your child have **stool / bowel accidents**? Specify:
Y	**N**	19. Does your child have **urine accidents**? Specify daytime, nighttime, or both?
Y	**N**	20. Does your child have problems with **frequent or painful urination**? Specify:
Y	**N**	21. Has your child ever had **tics or nervous twitches**, such as repeated eye blinking, head jerking, or throat clearing?
Y	**N**	22. Has your child had **seizures**? Specify:
Y	**N**	23. Has your child had any **difficulties with growth or his/her weight**? Any **special diets,** such as gluten/casein free? Specify:
Y	**N**	24. Does your child have any **birth defects** or **birthmarks**? Specify:
Y	**N**	25. Does your child have any problems with **rashes?** Specify:
Y	**N**	26. Does your child have any problems with **anemia, easy bruising, bleeding?** Specify:
Y	**N**	27. Does your child have any problems with their **muscles, bones, or joints?** Specify:
Y	**N**	28. Does your child have any problems with **frequent infections, or his/her immune system?** Specify:
		29. What is your child's **immunization status**? Check: ☐ Up to date ☐ Selected immunizations only ☐ Due for additional immunizations ☐ Not immunized

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Developmental-Behavioral Pediatrics
Parent Questionnaire- Under 3 Years

Child's Name (Last, First):

HISTORY: Prior Health Testing

Has your child had any of the following tests? Check those done. When? What were the results (if known)?

- ☐ MRI
- ☐ EEG
- ☐ Genetic Tests
- ☐ Hearing/Audiology Tests
- ☐ Vision Screen/Exam

HISTORY: Behavior

Y	N	
Y	N	1. Does your child have **many temper tantrums**?
Y	N	2. Did/Do you have **trouble keeping a babysitter** because of your child's behavior?
Y	N	3. Does your child often have **nightmares**?
Y	N	4. Does your child have any **problems falling asleep** at night? Specify:
Y	N	5. Does your child have any **problems staying asleep** through the night? Specify:
Y	N	6. Does your child have any **problems getting up** in the morning? Specify:
		7. At what time does your child **go to bed**?_____**fall asleep?**_____**wake up?** _____
Y	N	8. Does your child **snore** at night?
Y	N	9. Does your child often seem **tired or sleepy during the daytime**?
Y	N	10. Does your child have **problems with eating**? Specify:
Y	N	11. Does your child chew on or eat **non-food items** (such as toys, dirt/rocks, other objects)?
Y	N	12. Does your child have any **sensory sensitivity**, such as to sounds, touch, food textures? Specify:

HISTORY: Family Health

Is there anyone related to your child who has:				If yes, how is this person related to your child?
Y	N	Don't Know	1. ADHD / ADD (hyperactivity or attention problems)?	
Y	N	Don't Know	2. Alcohol problems?	
Y	N	Don't Know	3. Anxiety?	
Y	N	Don't Know	4. Autism Spectrum (e.g. Autism, Asperger, PDD-NOS)?	
Y	N	Don't Know	5. Bipolar Disorder / Manic Depression?	
Y	N	Don't Know	6. Heart problems before age 50 years or sudden death?	
Y	N	Don't Know	7. Delays in development or in speech/language?	
Y	N	Don't Know	8. Depression?	
Y	N	Don't Know	9. A History of physical or sexual abuse?	
Y	N	Don't Know	10. Learning or reading difficulty?	
Y	N	Don't Know	11. Mental Retardation or Intellectual Disability?	
Y	N	Don't Know	12. Neurologic problems?	
Y	N	Don't Know	13. Schizophrenia?	
Y	N	Don't Know	14. Seizures?	
Y	N	Don't Know	15. Tics or Tourette's disorder?	
Y	N	Don't Know	16. Receives/received special education when in school?	
Y	N	Don't Know	17. Receives/received services from the San Diego Regional Center?	
Y	N	Don't Know	18. Any of the above suspected but not diagnosed? Please explain:	
Y	N	Don't Know	19. Other diagnoses or health problems not listed above:	

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Developmental-Behavioral Pediatrics
Parent Questionnaire- Under 3 Years

Child's Name (Last, First):

HISTORY: Child's Past/Current Treatment

Y **N** 1. Has your child **had prior diagnoses by a professional**? If yes, which diagnoses? When? By whom?

- ☐ ADHD
- ☐ ADD
- ☐ Mental retardation/Intellectual disability
- ☐ Autism
- ☐ PDD-NOS
- ☐ Apraxia
- ☐ Asperger
- ☐ Learning Disorder
- ☐ Other
- ☐ Anxiety
- ☐ Depression
- ☐ Developmental Delay
- ☐ Cerebral Palsy

Y **N** 2. Has your child **ever taken medication for any of these concerns?**
If yes, do you know the **name**, **dose,** and **time(s) of day** the medication was given?

Name	Dose	Time(s) of Day	Check if your child is currently taking this medication
a.			☐
b.			☐
c.			☐
d.			☐

Y **N** 3. Were you **satisfied** with the medication's effect on your child's symptoms? Explain:

Y **N** 4. If medications were indicated for your child, would you be open to treatment with medication? Explain:

Y **N** 5. Are you hoping that there might be medication to address your child's concern? Explain:

6. **Which medication(s), including vitamins or herbal supplements, is your child currently taking?**

Name	Dose	Time(s) of Day
a.		
b.		
c.		
d.		
e.		

Are you **satisfied** with your child's current medication(s)? ☐ **Yes** ☐ **No** Explain:

7. **Are there any professionals (**such as doctors, psychiatrists, psychologists, social workers, occupational therapists, speech therapists, physical therapists, or other treatment professionals) **currently involved in your child's care? Please list them and their role in your child's care:**

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Developmental-Behavioral Pediatrics
Parent Questionnaire- Under 3 Years

Child's Name (Last, First):

HISTORY: Child's Past/Current Services Please mark in the column which services your child has had or currently receives. Please provide details.

Services	Past	Current
504 Plan		
Applied Behavioral Analysis Therapy		
CA Early Start or other early intervention program		
Occupational Therapy		
Physical Therapy		
Regional Center		
School IEP – indicate if your child is in the process of an evaluation for an IEP *Being considered under:* ☐ Speech Language Impaired ☐ Specific Learning Disability ☐ Mental Retardation/Intellectual Disability ☐ Other Health Impairment ☐ Autism ☐ Orthopedic Impairment ☐ Other (Specify):		
Social Skills Group/Training		
Special Education Preschool		
Speech/Language Therapy		
Other Therapy or Treatment. Please Specify:		

HISTORY: Changes or Stressors

Y	N	
Y	N	1. Have there been any **major changes or stresses** in your child's life? (Check all that apply): ☐ Marital Problems ☐ A Move ☐ Change of School ☐ Birth of a brother or sister ☐ Death of a pet ☐ Other If yes, please specify and include how old the child was at the time: Is this stress still occurring? ☐ Yes ☐ No
Y	N	2. Has there been a **serious illness or death** in a parent or close family member of your child? If yes, please specify and include how old the child was at the time:
Y	N	3. Are any **major changes or stresses** expected in the future? If yes, please specify:
Y	N	4. Has your child **experienced or seen any traumatic events** (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time: Is this trauma still occurring? ☐ Yes ☐ No

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Developmental-Behavioral Pediatrics
Parent Questionnaire- Under 3 Years

Child's Name (Last, First):

HISTORY: Child's Living Arrangements

1. How would you describe the **current relationship** between your child's **biological parents**?

☐ Friendly / Amicable
☐ Unfriendly / Conflict ridden
☐ No relationship
☐ Not Applicable (please specify):
☐ Don't Know

2. Is your child adopted? ☐ Yes ☐ No If yes, does your child know that he/she is adopted? ☐ Yes ☐ No

Is your child in foster care? ☐ Yes ☐ No Explain:

Y	N	
		3. Are there any **immediate family members** who do not live with your child (biological mother, biological father, or siblings)? If yes, please specify relationship to child:

4. **Please list all people who are currently living in your child's household.**

Name	Relationship to Child	Age	Name	Relationship to Child	Age

5. Please list the **highest educational level** achieved by your child's biological parents:

Mother:
Father:

6. Please list the **job/occupation** of your child's biological parents:

Mother:
Father:

HISTORY: Military Family

Y	N	
		1. Are you or another parent/guardian of your child currently in the Military? If Yes, which branch? ☐ Navy ☐ Marine ☐ Air Force ☐ Army ☐ Other (specify):
		2. Are any of your child's parent(s)/guardian(s) Active Duty Military? If yes, who: ☐ Mother ☐ Father ☐ Both ☐ Other:
		3. Are they deployed or deployable? ☐ Yes ☐ No
		4. When did you PCS/Move to this Location? Date:
		5. When are you due to PCS / Move? Date:
		6. Is your child or other members of this family in the Exceptional Family Member Program?
		7. Is your child or other members of this family part of the Extended Health Care Option?

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Developmental-Behavioral Pediatrics
Parent Questionnaire- Under 3 Years

Child's Name (Last, First):

HISTORY: Summary

Please **summarize your child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings-- home, school, and with peers, to "average children" his/her age that you 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)

Is there anything else that you think would be helpful for the evaluation team to know? Please describe: